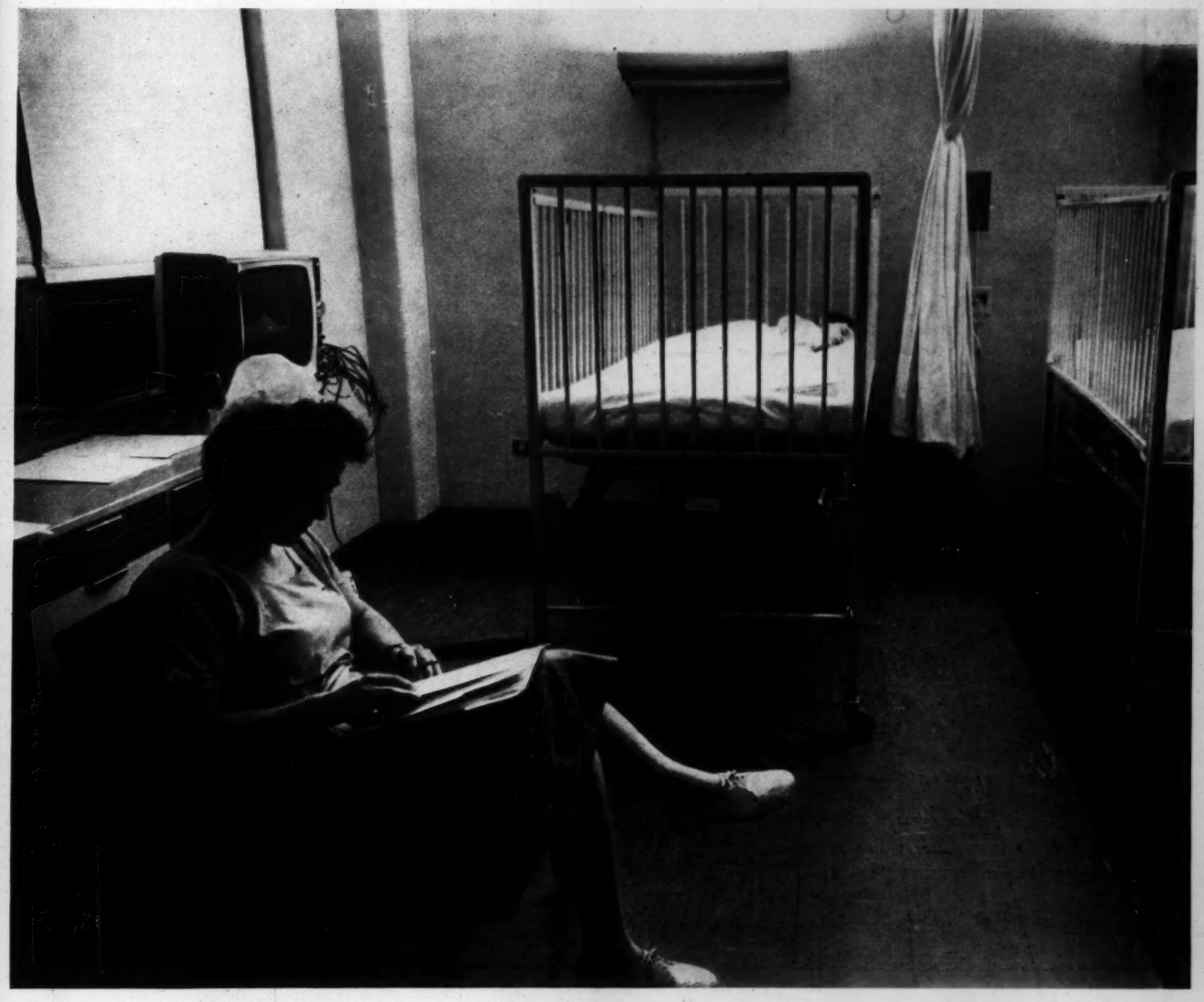
63RD ANNUAL MEETING • ATLANTIC CITY • SEPT. 25-28

HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

JUNE 1, 1961



A CONSTANT CARE PROGRAM FOR 'T AND A' PATIENTS

For fewer transfusions . . .
clearer operative field . . .
less postoperative nursing . . .

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SALICYLATE

(Brand of carbazochrome salicylate)

The patient, surgical team and nursing staff all benefit when Adrenosem is part of the preoperative routine because it helps maintain capillary integrity.

Adrenosem decreases excessive capillary permeability and promotes retraction of severed capillary ends, thus diminishing excessive bleeding. This conserves the patient's own blood so less is needed from the blood bank. Since the operative field is clearer, surgical procedures are facilitated and operating time shortened. In the postoperative period, reduction in seepage and oozing means fewer calls on the nursing staff.

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*U.S. Pat. Nos. 2581850; 2508294

SUPPLIED: *For oral administration* —**Tablets:** 1 mg. (s.c. orange), bottles of 50, and 2.5 mg. (s.c. yellow), bottles of 50. **Syrup:** 2.5 mg. per 5 cc. (1 tsp.), bottles of 4 oz.

For I.M. injection—**Ampuls:** 5 mg., 1 cc., packages of 5 and 100; 10 mg., 2 cc., packages of 5.

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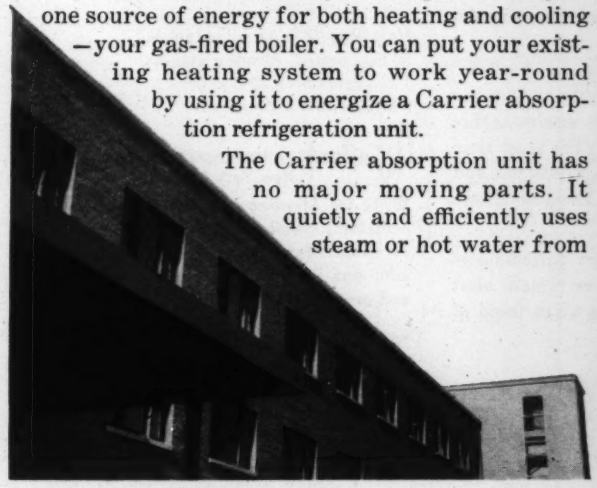
The Carrier absorption unit has no major moving parts. It quietly and efficiently uses steam or hot water from a gas-fired boiler to provide chilled water for cooling air in summer. The same boiler delivers steam for heating in winter, and all year long it supplies steam for sterilizers, laundry and other hospital needs. Fuel costs stay low with thrifty gas.



Quiet, dependable, economical gas and Carrier absorption refrigeration provide ideal climate all year. For details, call your local Gas Company, or write to Carrier Air Conditioning Company, Syracuse 1, New York. *American Gas Association*

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Analgesic potency as great as morphine without drowsiness or hypnosis*

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Dosage: Orally, from 25 to 50 mg. every four to six hours as required. By subcutaneous or intramuscular injection, from 10 to 20 mg. every four hours as required.

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*In more than 90% of patients.

HOSPITALS

Journal of the American Hospital Association

Published by the American Hospital Association; **Edwin L. Crosby, M.D.**, executive vice president and director

Volume 35 **Number 11** **June 1, 1961**

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articles

How Hospitals and Nursing Homes Can Work Together . . *Robert Morris* 32

A Constant Care Program for 'T & A' Patients . . . . . *Martin Saren and Herbert Abramson* 37

Four Departments, One Aim: Find a Better Way . . . . . *Carl F. Thielmann* 40

Let's Keep Background Music in the Background . . . . . *Richard H. Barrett, M.D.* 44

Health Care in India: Its Patterns and Problems—Part 2 . . . . . *John R. McGibony, M.D.* 47

Getting the Most Out of Buying on Bid . . . . . *Edward Blaszczyk* 60

Search for Efficiency Through the Dietary Budget . . . . *Kenneth Wallace* 68

Infections as a Maintenance Problem . . . . . *George E. Linney* 84

departments

Engineering and Maintenance . . 84

Food Service and Dietetics 68

Professional Practice 55

Purchasing 60

regular features

Book Reviews 86

Calendar of Association and Allied Meetings 6

Digest of News 17

Editorial Notes 31

Equipment and Supply Review . . 79

Introducing the Authors 15

Law in Brief 93

News 97

Officers, Trustees and Councils of the American Hospital Association 12

Opinions and Ideas 21

Personnel Changes 89

Service from Headquarters 27

Washington Report 91

Your President Reports 53

cover

The all-night vigil of the nurse in the special room for tonsillectomy and adenoidectomy patients at Long Island Jewish Hospital, New Hyde Park, N.Y., typifies the hospital's "constant care" program for these patients. An article describing the program begins on page 37. Cover photo by Arthur Leipzig. (Credits for other photos in this issue are on page 106.)

Classified Advertising 105

Index to Advertisers 106

HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill. TEL. WHitehall 4-4350. Second class postage paid at Chicago, Illinois. SUBSCRIPTION RATES: $5 for 1 year; $12 for 3 years. Single copies 30 cents, except the two-part August 1, Guide Issue $2.50. (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as the new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified.

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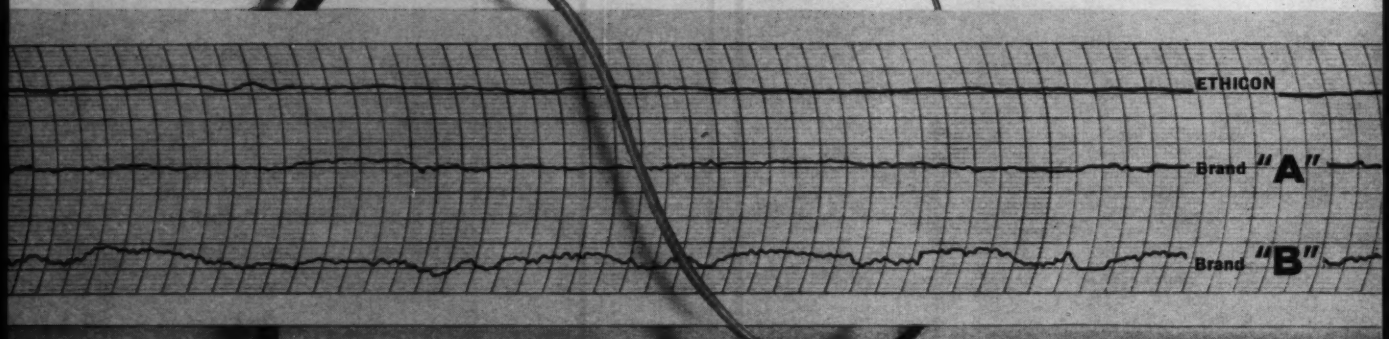

ETHICON suture strand taken from regular package, immersed 30 seconds in water, and straightened.

Brands "A" and "B"-sutures of two other leading manufacturers—strands were taken from regular package, immersed 30 seconds in water, and straightened.

All three strands were then scanned electronically in a Profilometer and the results recorded on the chart shown above.

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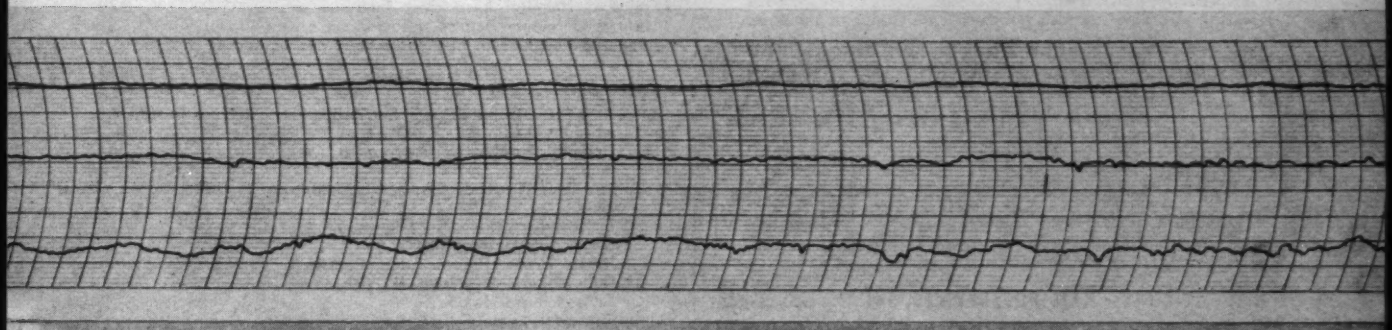

The proof of a suture's uniformity is in its profile. This reproduction of actual electronic readings as recorded by Profilometer microgauge scanner proves that ETHICON Surgical Gut is more uniform. Such uniformity is the result of ETHICON TRU-GAUGING — a unique process that assures uniform strength from end to end . . . **and** from strand to strand.

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AMERICAN HOSPITAL ASSOCIATION

NATIONAL MEETINGS

1961

Sept. 25-28—**63rd Annual Meeting,** Atlantic City (Convention Hall)

MEETING AND INSTITUTE CALENDAR

THROUGH NOVEMBER 1961

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. *Other organizations in the health field are shown in ITALICS.)*

JUNE

1-2 New Hampshire Hospital Association, Newcastle (Wentworth-by-the-Sea)
5-7 **Hospital Purchasing (Advanced),** Chicago (AHA Headquarters)
5-8 Maritime Hospital Association, Halifax, N.S. (Nova Scotian Hotel)
5-9 International Hospital Federation, 12th International Hospital Congress, Venice, Italy
6-7 Maine Hospital Association, Rockland (Samoset Hotel)
6-8 **Patterns and Principles for Auxiliary Leaders,** Washington, D.C. (Willard Hotel)
11-16 American Society of Medical Technologists, Seattle (Olympic Hotel)
12-15 **Nursing Service Supervision,** Chicago (AHA Headquarters)
12-15 Catholic Hospital Association, Detroit (Cobo Hall)
14 Connecticut Hospital Association, Berlin (Connecticut Light and Power Co.)
18-20 Michigan Hospital Association, Grand Rapids (Hotel Pantlind)
19-21 **Administrators' Secretaries,** Chicago (AHA Headquarters)
19-23 **Hospital Pharmacy (General),** Albany, N.Y. (Sienna College)
21-23 North Carolina Hospital Association, Asheville (Grove Park Inn)
24-29 *International Convention of X-ray Technicians,* Montreal (Queen Elizabeth Hotel)
25-30 *American Medical Association,* New York City (Coliseum)
26-28 Comité des Hopitaux du Québec, Montreal (Show Mart)
26-28 **Supervision,** Little Rock (University of Arkansas Medical Center)

JULY

2-7 *American Physical Therapy Association,* Chicago (Palmer House)
12-14 Mississippi Hospital Association, Biloxi (Buena Vista Hotel)
16-21 *19th Annual Institute of the American Association of Hospital Accountants,* Indiana University, Bloomington
31-Aug. 4 **Hospital Purchasing (Advanced),** Kansas City (Bellerive Hotel)

AUGUST

7-11 **Hospital Pharmacy,** San Francisco (Guy S. Millberry Union, University of California)
24-26 *Canadian Association of Physical Medicine and Rehabilitation,* Saskatoon, Sask. (Bessborough Hotel)
29-30 **Credits and Collections,** Portland (Hotel Benson)

SEPTEMBER

7-8 Montana Hospital Association, East Glacier Park (East Glacier Hotel)
11-15 **Hospital Engineering,** Washington, D.C. (Willard Hotel)
11-15 **Central Service Administration,** Chicago (AHA Headquarters)
23 *American Association of Hospital Consultants,* Atlantic City (Shelburne Hotel)
23-25 *American College of Hospital Administrators,* Atlantic City (Convention Hall)
25-28 *American Association of Nurse Anesthetists,* Atlantic City (Convention Hall)

(Continued on page 8)

Deionize, Distill, Sterilize RAW WATER

To appropriate hospital standards... dependably, at minimum cost

AMSCO Water Processing equipment is indeed so complete in scope as to encompass every conceivable hospital water need . . . whether it be deionization or complex triple distillation and sterilization for "lifesaving" parenterals.

Our "Deluxe" Steam Heated Water Stills routinely exceed the most rigid hospital purity standards. These quality stills are available with proper controls and storage tanks for any application. Where economy is a factor, our "Utility" Water Stills produce a high standard distillate . . . at minimum cost. Again, controls and storage tanks to suit the need.

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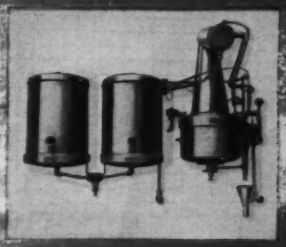

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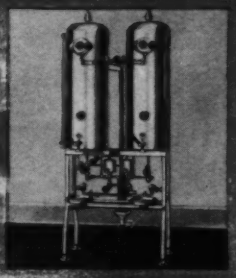
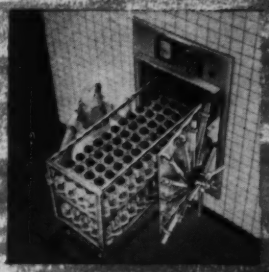


WATER STERILIZERS
• 10, 15, 25-gallon capacities, single or double reservoir. Steam, Electric or Gas heat. Also Cystoscopic Water Sterilizers.



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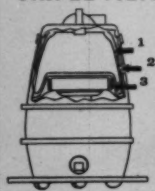

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2 A secondary filter bag of scientifically processed cloth.

3 A final chamber mounted filter permits only thoroughly cleaned air to leave the cleaner.

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29-Oct. 8 ***American Society of Clinical Pathologists,*** Seattle (Olympic Hotel)

OCTOBER

2-4 **Hospital Laundry Management and Operation,** Baltimore (Lord Baltimore)
2-6 ***American College of Surgeons,*** Clinical Congress, Chicago (Conrad Hilton Hotel)
2-6 ***American Nursing Home Association,*** Cleveland (Pick-Carter Hotel)
2-6 ***National Federation of Licensed Practical Nurses, Inc.,*** St. Paul (Saint Paul Hotel)
5-6 Saskatchewan Hospital Association, Regina (Hotel Saskatchewan)
9-12 ***American Association of Medical Record Librarians,*** Philadelphia (Benjamin Franklin Hotel)
9-13 **Nursing Service Administration,** Chicago (AHA Headquarters)
10 Hospital Association of Rhode Island, Providence (Sheraton-Biltmore Hotel)
10-12 Associated Hospitals of Alberta, Calgary (Hotel Palliser)
11-12 Vermont Hospital Association, Burlington (Vermont Hotel)
11-13 **Hospital Safety and Insurance,** Dallas, Tex. (Adolphus Hotel)
11-13 Missouri Hospital Association, St. Louis (Sheraton-Jefferson Hotel)
12 Association of Delaware Hospitals, Dover
12-13 Nebraska Hospital Association, Lincoln (Cornhusker Hotel)
16-17 ***National Council on the Aging,*** New York City
16-17 Idaho Hospital Association, Boise (Elks Lodge)
16-18 **Management Development,** Chicago (AHA Headquarters)
16-19 **Staffing Departments of Nursing,** Cincinnati (Sheraton-Gibson Hotel)
16-19 ***American Dental Association,*** Philadelphia (Sheraton Hotel and Convention Hall)
17-18 South Dakota Hospital Association, Sioux Falls (Sheraton-Cataract Hotel)
17-19 British Columbia Hospital Association, Vancouver (Hotel Vancouver)
19-20 Arizona Hospital Association, Phoenix (Ramada Inn)
19-21 West Virginia Hospital Association, Morgantown (Morgan Hotel)
22-24 Oregon Hospital Association, Eugene (Eugene Hotel)
22-25 Colorado Hospital Association, Boulder (Harvest House)
22-27 ***American Society of Anesthesiologists, Inc.,*** Los Angeles (Statler Hilton Hotel)
23-25 Ontario Hospital Association, Toronto (Royal York Hotel)
23-27 California Hospital Association, San Diego (El Cortez Hotel)
24-27 ***American Dietetic Association,*** St. Louis (Jefferson-Sheraton Hotel and Kiel Auditorium)
25-28 ***American Association of Blood Banks,*** Chicago (Drake Hotel)
26-27 Washington State Hospital Association, Yakima (Chinook Hotel)

NOVEMBER

1-3 Indiana Hospital Association, French Lick (French Lick Hotel)
2-3 Oklahoma Hospital Association, Tulsa (Mayo Hotel)
2-4 **Hospital Directors of Medical Education,** Chicago (AHA Headquarters)
5-11 ***American Occupational Therapy Association,*** Detroit
6-10 **Physical Therapists,** Miami, Fla. (Deauville Hotel)
6-10 **Hospital Pharmacy (Specialized),** Chicago (AHA Headquarters)
8-10 Maryland-D.C.-Delaware Hospital Association, Washington (Shoreham Hotel)
9-10 Kansas Hospital Association, Hutchinson (Baker Hotel)
9-10 Minnesota Hospital Association, Minneapolis (Leamington Hotel)
9-10 Virginia Hospital Association, Richmond (John Marshall Hotel)
13-15 ***Association of American Medical Colleges,*** Montreal, Quebec, Canada (Queen Elizabeth Hotel)
13-17 ***American Public Health Association,*** Detroit (Cobo Hall)
13-17 **Hospital Housekeeping (Advanced),** Chicago (AHA Headquarters)
13-17 **Dietary Department Administration,** Boston (Somerset Hotel)
14-16 **Directors of Hospital Volunteers,** Denver (Cosmopolitan Hotel)
26-Dec. 1 ***Radiological Society of North America,*** Chicago (Palmer House)
27-30 **Operating Room Administration (Advanced),** Indianapolis (Sheraton-Lincoln Hotel)
28-30 **Hospital Dental Service (Advanced),** Chicago (AHA Headquarters)
30-Dec. 1 Illinois Hospital Association, Springfield (St. Nicholas Hotel)

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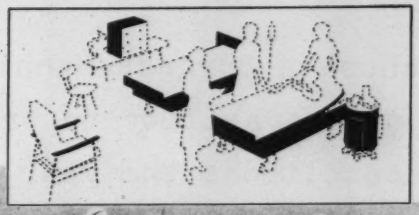

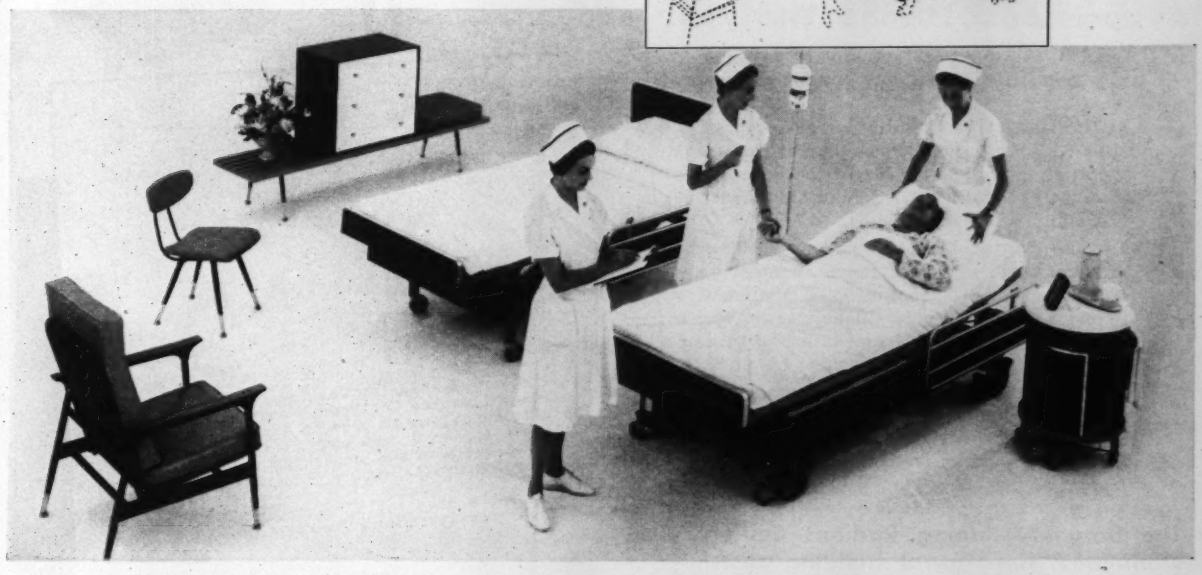

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Consulting Engineer

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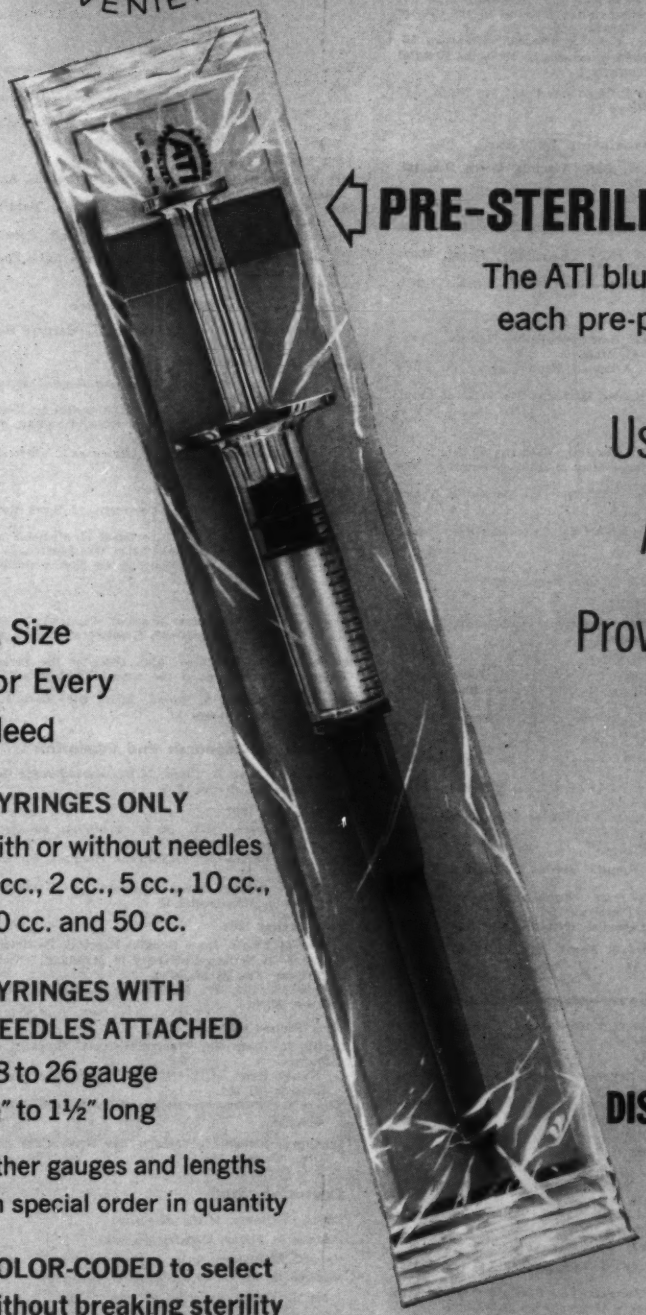

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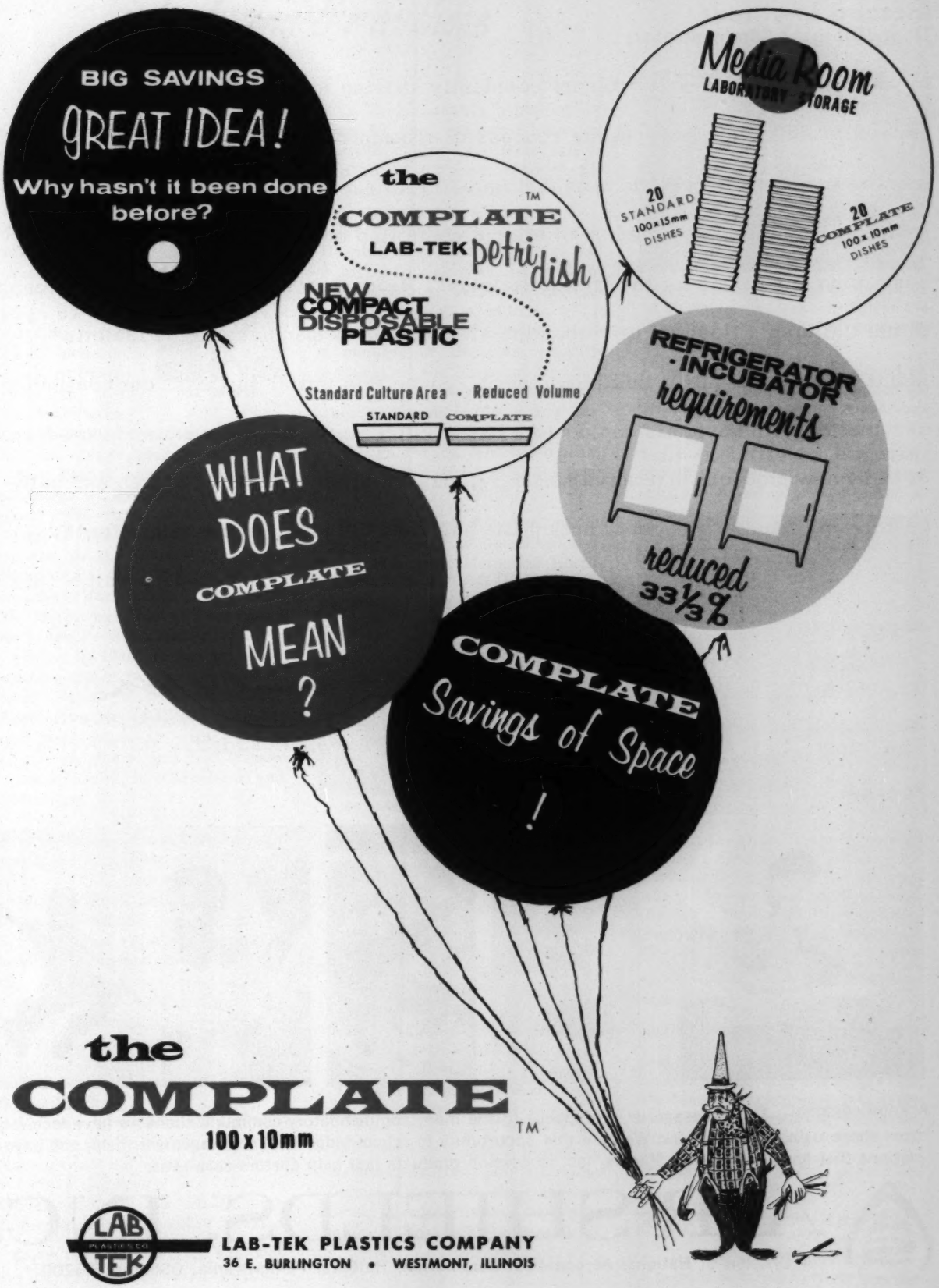
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introducing the authors

Robert Morris, associate professor of community planning, the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass., says in his article beginning on page 32 that nursing homes have reached such proportions that it is necessary to examine their integration into other medical care organizations.

MR. MORRIS

Mr. Morris has been associate professor at Brandeis University since 1959. Prior to this, for 10 years, he was social planning consultant for the Council of Jewish Federations and Welfare Funds, Inc., New York. From 1946 to 1948, Mr. Morris was chief of social service at the Veterans Administration, Chicago. In 1945, he was principal welfare officer for the United Nations Relief and Rehabilitation Administration (UNRRA). He has also held positions with various public assistance and family case work agencies in Cleveland and Baltimore.

Presently, Mr. Morris is chairman of the social work service advisory council, Veterans Administration, Washington, D.C., and chairman of the publications committee, National Association of Social Workers. His membership in other professional associations includes the American Public Health Association, Massachusetts Public Health Association, Society for Psychological Study of Social Issues and the United States Committee, International Conference of Social Work.

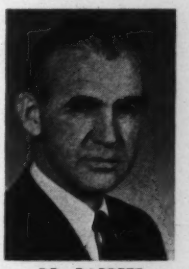
Mr. Morris received his A.B. degree from the University of Akron, Akron, Ohio; his M.Sc. degree from Western Reserve University, Cleveland; and his Ph.D. from Columbia University, New York.

Carl F. Thielmann, methods engineer at the Toledo (Ohio) Hospital, says, in his article beginning on page 40, that the same basic industrial engineering tools can be applied to different hospital departments with concrete results in each department.

Mr. Thielman joined the Toledo Hospital in 1958 after five years of industrial experience. In 1960, he was appointed personnel director for the hospital in addition to his duties as industrial engineer. He is a member of the Ohio Hospital Association, the American Institute of Industrial Engineers and the Toledo Personnel Managers Association.

Mr. Thielmann received his B.S. degree in industrial relations from the University of Buffalo.

Richard H. Barrett, M.D., chairman of the department of anesthesiology, Mary Hitchcock Memorial Hospital, Hanover, N.H., states that background music in hospitals should be carefully programed and controlled and that equipment should be in excellent condition if the music is to achieve its purpose (article begins on page 44).



DR. BARRETT

Dr. Barrett, a graduate of the University of Vermont, Burlington, Vt., did his graduate work in anesthesiology at the University of Minnesota, Minneapolis. He has been associated with the Mary Hitchcock Memorial Hospital since 1941. He also serves as assistant professor of anesthesiology, Dartmouth College Medical School.

Dr. Barrett is active in many medical organizations including the New Hampshire Medical Society, the New England Society of Anesthesiologists, the American Medical Association, the American Society of Anesthesiologists and the American Board of Anesthesiology, of which has been director since 1959.

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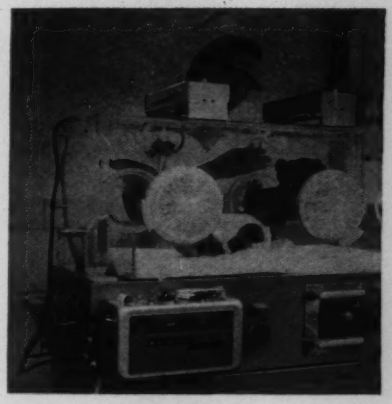

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CALIFORNIA OSTEOPATHS AND MEDICAL DOCTORS AGREE TO UNIFY—The house of delegates of the California Osteopathic Association (COA) voted overwhelmingly on May 17 to unite with the California Medical Association. The house of delegates of the medical association approved a similar resolution May 3 by a 269 to 63 vote. The recent COA vote was 100 to 10.

The COA lost is national charter last November for carrying on negotiations with the state medical society for a merger of the two groups. In January, the American Osteopathic Association granted a charter to a new state osteopathic society, the Osteopathic Physicians and Surgeons of California. This group filed a Superior Court suit in April seeking to block the COA-CMA merger, but on May 15 the court refused to grant a temporary injunction. The merger was opposed as an effort to create a "health care monopoly" in California.

KENTUCKY CHARITABLE INSTITUTIONS NOT IMMUNE FROM TORT LIABILITY—The doctrine of charitable immunity was abolished in Kentucky when the state Court of Appeals ruled on May 10 that the charitable nature of an institution was not sufficient to exempt it from liability for its own negligence.

In reversing its stand on charitable immunity, the court stated: "When there is negligence the rule is liability. The rule of immunity of charitable institutions such as we have in this case is indeed an exception which seems to have crept into our laws under the pressure of expediency. Upon applying the simple test of right and wrong we are forced to the conclusion that the charitable nature of a wrongdoer should create no exception to the rule of liability."

REPORT FROM WASHINGTON—A record $4.02 billion, approved by the House Appropriations Committee for the Department of Health, Education, and Welfare, was passed by the House May 17. A new allotment of $10 million for grants for construction of hospital research facilities is included in the appropriation.

These grants, which would be administered outside the Hill-Burton hospital construction program, were not requested by the Kennedy Administration in its budget for HEW and were opposed in the American Hospital Association testimony to the 87th Congress. The recommendations, are now scheduled for Senate consideration.

- Congress will hold hearings this year on the Kennedy Administration aged health care plan, it was announced by the chairman of the House Ways and Means Committee. The plan will be taken up following consideration of President Kennedy's tax proposals. The Anderson-King measure (H.R. 4222), pending since February 13, calls for social security financing of specified days of hospital, nursing home and home health services and outpatient diagnostic care for senior citizens.
- Vendor payments under the Kerr-Mills Act are showing a steady growth according to the Department of Health, Education, and Welfare figures. In February 1961, five states were participating and payments totaled $3,852,628 for 18,678 recipients. *(Details p. 91).*

INCREASED MEDICARE FUNDS ASKED—The Department of Defense has asked for an appropriation of $73.2 million for the fiscal year 1962 for its Medicare program. The figure, which was reported at a Senate Appropriations Subcommittee hearing on new defense funds, is $1.6 million higher than last year's appropriation. The increase was requested to cover a larger number of dependents of armed services personnel eligible for civilian medical and hospital services, as well as higher costs.

It is estimated that there will be 3,946,000 dependents in the fiscal year ending June 30, 1962. This would be an increase of about 79,400 over the current fiscal year.

A recent tally on Medicare payments showed $270 million in federal funds paid between the start of the program in December 1956 and December 1960. Of this total, civilian hospitals received $133 million and civilian physicians $130 million. The remainder was for administrative costs.

NURSING HOMES STUDY SET—The new Senate Special Committee on Aging has adopted a four-point program for this year. First on the agenda is a study of conditions and standards in nursing homes, scheduled to start in June with Washington, D.C., institutions. The other three are studies of public and private programs relating to retirement income, housing and organization of federal and state programs dealing with the aged.

The District of Columbia nursing home study will be carried out by a special subcommittee which will subsequently hold regional meetings in other areas of the country. In addition to the advantage of proximity, the Washington, D.C., area was chosen for the initial study because of recent controversy there over regulations between District officials and nursing home operators. The U.S. Public Health Service will cooperate in the study.

HEADQUARTERS BUILDING PLANNED BY TEXAS ASSOCIATION—A plan to construct a headquarters building for the Texas Hospital Association was unanimously approved by the house of delegates of the association at a session during the annual meeting of THA in Dallas May 15-17. The project will be financed through a temporary dues increase to be imposed Jan. 1, 1962, for a five-year period.

To be built in Austin at an approximate total cost (including land) of $200,000, the building will also house offices of various state paramedical groups primarily composed of hospital employees. Facilities for educational programs

sponsored by the Texas association and other groups will be provided.

Construction is scheduled to begin by September 1962, with completion set for March of the following year. *(A full report of the Texas Hospital Association meeting will appear in the June 16 issue of this Journal.)*

TRI-STATE HOSPITAL ASSEMBLY MEETS IN CHICAGO—A continued increase in the use of hospital facilities and in the cost of hospital care was forecast at the 31st annual Tri-State Hospital Assembly in Chicago, May 1-3.

George Bugbee, president, Health Information Foundation, New York, and former director of the American Hospital Association, predicted that the hospital will tend to become more a center of long-term care with a wider range of organizational services.

Other subjects explored at the assembly included the effect of federal legislation on financing of health care of the aged, patient care research and manpower shortages. *(Details p. 97)*

MORE THAN 1700 ATTEND SOUTHEASTERN HOSPITAL CONFERENCE—Hospital personnel resources and safety records of hospitals were topics on the agenda of the Southeastern Hospital Conference in Memphis, Tenn., April 19-21.

David B. Wilson, M.D., director of University Hospital, Jackson, Miss., told a general assembly audience that hospitals must be willing to train personnel. "They cannot afford to use untrained personnel and expect to deliver a high level of service," he said. *(Details p. 100)*

AGED MEDICAL CARE DISCUSSED AT MID-WEST HOSPITAL ASSOCIATION MEETING—Opposing views on the Kerr-Mills Act and President John F. Kennedy's plan for medical care for the aged were expressed at the 33rd annual Mid-West Hospital Association Meeting in Kansas City, April 26-28.

Nelson H. Cruikshank, director of the Department of Social Security, AFL-CIO, and proponent of the Kennedy plan, said that organized labor was not against the Kerr-Mills Act, but said that the act should be regarded only as a supplementary program. Frank S. Groner, president of the American Hospital Association, said that the real issue was essentially that of local authority versus federalism. *(Details p. 98)*

QUEBEC HOSPITAL ASSOCIATION HEARS PRIME MINISTER LESAGE—The government of Quebec is prepared to enact legislation governing the administration and operation of hospitals in the province, based on recommendations from hospital and medical associations, Prime Minister Jean Lesage told delegates attending the Quebec Hospital Association annual meeting in Montreal, April 19-21. The prime minister said the government was anxious to assist, but did not want to infringe upon the autonomy of hospitals. He urged hospital and medical associations to "inspire" a Hospital Act by drafting recommendations for the proposed government legislation. *(Details p. 102)*

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opinions and ideas

(LEFT) Scene in the Mary Fletcher Hospital where public relations office manager (left) and hospital print shop employee are conferring on the production of the *Gauzette*, the publication for employees. The offset printing press shown was presented to the hospital by the hospital auxiliary.

Hospital news for public and personnel

Why two monthly publications issued by one hospital? The Mary Fletcher Hospital, Burlington, Vt., has found it worthwhile to distribute one publication for the public and one for personnel, according to Robert L. Burger, director, public relations and development, because of the different interest and point of view represented by the two groups of readers.

The *Mary Fletcher Progress,* the newspaper for the public, has a circulation in excess of 6000, and is sent without charge to all volunteers, donors, physicians on the staff and throughout the state, to all Vermont lawyers, ministers, health organizations and news media, and to anyone else who requests a copy. The *Gauzette,* the inhospital publication, is distributed to approximately 475 employees, all staff physicians, students and the board of directors.

Both publications are produced by the offset process, but *Progress* is produced at a local printer, while *Gauzette* is printed in the hospital on a press presented to the hospital by the hospital auxiliary.

A definite schedule is followed in preparing the *Progress,* according to Mr. Burger. During the first 10 days of the month, articles are prepared by him. Copy is typed for the offset cameras the 11th through the 13th of each month, followed by page make-up or "paste-up" at the local printers on the 14th. The completed four-page, (single-fold) newspaper is delivered to the hospital on the 18th of the month and reaches subscribers on the 20th.

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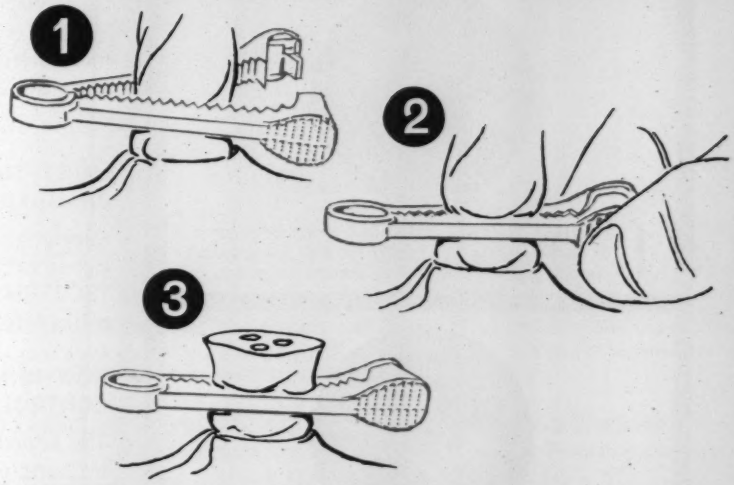

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HERE ARE THE FACTS ON THE NEW, HIGH-FILTRATION

SCOTCH SURGICAL MASK

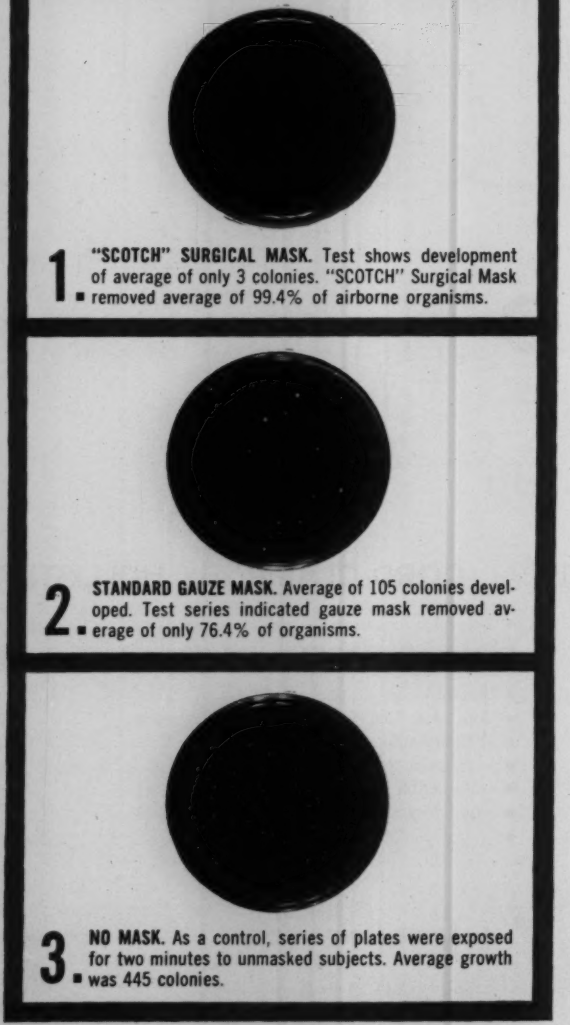
REG. U.S. PAT. OFF.

BRAND

HOW DOES THE "SCOTCH" BRAND SURGICAL MASK COMPARE IN FILTERING EFFICIENCY WITH GAUZE MASKS?

In hundreds of controlled comparative tests (utilizing both in-use and mechanical sampling methods ... both new and used masks ... both brief and sustained testing periods) the "SCOTCH" Surgical Mask averaged up to 35 times more effective than gauze in filtering out airborne bacteria.

TYPICAL TEST RESULT: (masked subjects, 2 minute test period)



1 ■ **"SCOTCH" SURGICAL MASK.** Test shows development of average of only 3 colonies. "SCOTCH" Surgical Mask removed average of 99.4% of airborne organisms.

2 ■ **STANDARD GAUZE MASK.** Average of 105 colonies developed. Test series indicated gauze mask removed average of only 76.4% of organisms.

3 ■ **NO MASK.** As a control, series of plates were exposed for two minutes to unmasked subjects. Average growth was 445 colonies.

WHY IS THE DESIGN AND CONSTRUCTION OF THE "SCOTCH" SURGICAL MASK SO EFFICIENT?

The "SCOTCH" Surgical Mask is molded of a new stabilized-porosity synthetic fabric with an unusually high filtration capacity. Unlike soft, woven fabrics such as gauze, its built-in porosity is permanent. There is little or no variation from mask to mask and no radical loss of efficiency due to compression, matting, or wetting during use.

HOW DOES THE CONTOURED SHAPE OF THE MASK INCREASE ITS FILTERING EFFICIENCY?

Because it is held away from the mouth and nostrils, virtually the entire inner surface of the "SCOTCH" Surgical Mask acts as a filter. Exhaled moisture droplets are not propelled through a small area, but are dissipated at low velocity within the mask.

MUST THE "SCOTCH" SURGICAL MASK BE CHANGED DURING PROLONGED PROCEDURES?

Rarely. Whereas gauze masks rapidly lose efficiency due to wetting and must be changed frequently, the "SCOTCH" Surgical Mask shows little or no drop-off in filtering effectiveness in extended use.

HOW IS LEAKAGE AROUND THE MASK EDGES CONTROLLED?

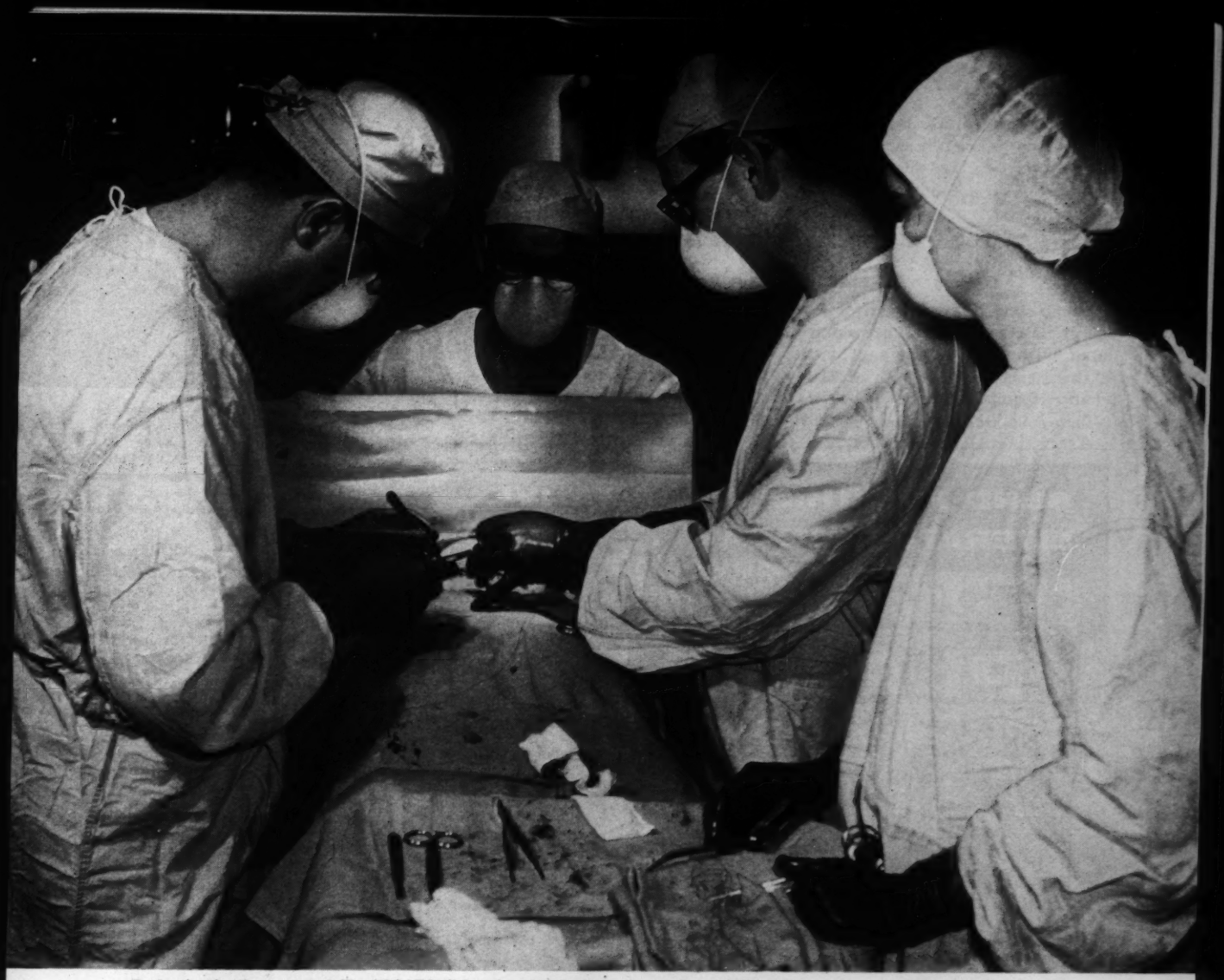
The adjustable nose piece, contour shape and elastic band of the "SCOTCH" Surgical Mask provide a close fit that minimizes air leakage. Fogging of glasses is almost totally eliminated.

DOES THE MASK'S HIGH FILTRATION MAKE BREATHING DIFFICULT?

Not at all. Because of its large effective filtering area, breathing is actually easy. There is no significant CO_2 build-up within the mask. Speech is not muffled.

WHAT ABOUT COMFORT?

The "SCOTCH" Surgical Mask has been called "the most comfortable yet." It is lightweight (9 masks weigh only one ounce). Measured skin temperatures have proved 1° cooler than inside gauze masks. Vision is not obstructed. Elastic band holds mask in correct position without slipping or binding. There are no strings to tie or adjust.



Enthusiastically accepted. The "SCOTCH" Surgical Mask shown in use in a leading midwestern hospital—one of the many institutions that have already standardized on this high-filtration disposable mask.

IS THE "SCOTCH" SURGICAL MASK EXPENSIVE TO USE?

No. An independent six-month cost study at a leading hospital showed virtually identical over-all costs whether the "SCOTCH" Surgical Mask or gauze masks were used. "SCOTCH" Surgical Masks cost approximately 9 cents each at quantity prices . . . eliminate all inspection, laundry and re-sterilization costs.

CAN THE MASK BE AUTOCLAVED?

Yes. While this mask is designed and priced to be fully disposable, it may be steam autoclaved with no loss of filtering efficiency.

HOW CAN YOU TRY THE "SCOTCH" SURGICAL MASK IN YOUR HOSPITAL?

Your surgical supply dealer can fill your trial order promptly—box of 50 masks, only $6.00; case of 10 boxes, $54.00†. Or, for free samples and additional literature, contact your 3M Sales Representative or write to 3M Company, Dept. NAJ 61, 900 Bush Avenue, St. Paul 6, Minnesota.

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SCOTCH BRAND SURGICAL MASK*

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bility of the hospital's public relations office manager, who meets monthly with her 16-member editorial staff representing various hospital departments, This publication, which varies from four to eight pages per issue, features personal news of hospital employees and news of the hospital from the employee's point of view.

Cribs with storage space used in Scottish hospital

A crib specially designed for the use of newborn infants accommodated with their mothers is used in the Elsie Inglis Memorial Maternity Hospital, Edinburgh.

This crib was described in *The Lancet*, by J. W. Farquhar, M.D., Department of Child Life and Health, Edinburgh University. Under the "rooming-in" arrangement, the mother does much of the work of caring for the baby, and utilizes the storage space in the crib for storing baby clothes and miscellaneous supplies for the baby's care. This crib can also be altered so that urine collections may be made.

A CRIB for newborn babies designed for use at the Elsie Inglis Memorial Maternity Hospital, Edinburgh, Scotland, provides storage space for articles needed for the baby's care under the "rooming-in" plan. A small locker is fitted to one end of the crib, and a larger one is mounted on parallel steel rods below the crib.

The canvas crib for the baby is mounted on a tubular steel folding frame with casters to permit easy moving. The canvas crib can easily be removed from the frame for laundering. Also it can be adjusted to lower one end if desired. A latex foam mattress is provided, covered with a single-faced hospital sheet fastened with a zipper.

Two lockers mounted on the steel frame provide storage space. A small locker fitted to one end of the crib holds an individual rectal thermometer and bathing supplies, including such items as dusting powder, oil and cream. A larger locker placed on parallel steel rods below the crib holds a day's supply of diapers, wraps, gowns and blankets. Both lockers may be removed from the frame for easy cleaning. They are fitted with hinged doors so that they close by gravity and are held shut by spring clips.

In order to modify the crib for urine collections, the larger locker below the crib is removed. Urine passes through a hole in the mattress and canvas crib and through latex tubing to a collecting bottle on a tray beneath the crib.

All parts of the crib may be easily cleaned, and the provision of individual supplies for each baby lowers the chance of transmitting infections.

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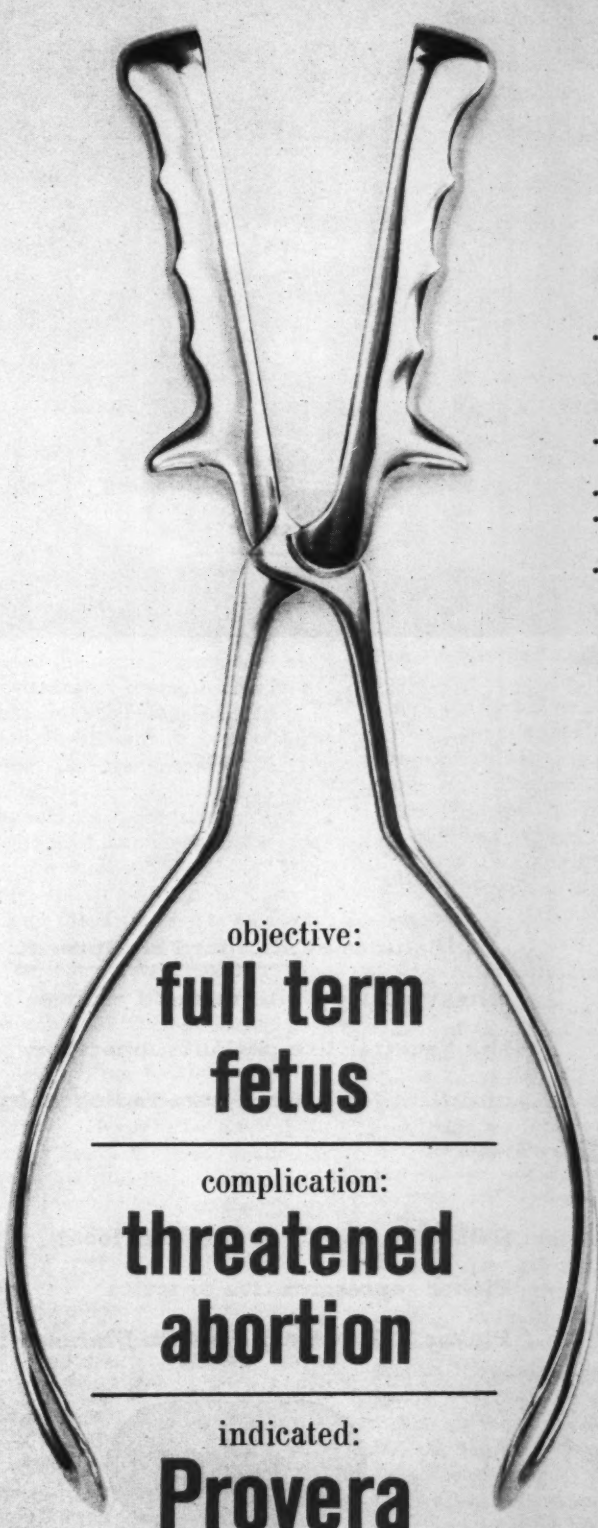

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full term fetus

complication:

threatened abortion

indicated:

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- Provera gives the economy of effective action from small doses.

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	● Oral Provera*	⟵ I.M. Depo-Provera**
Description	Upjohn brand of medroxyprogesterone acetate.	Aqueous suspension, 50 mg. Provera per cc., for intramuscular injection only.
Indications	Threatened and habitual abortion, infertility, dysmenorrhea, secondary amenorrhea, premenstrual tension, functional uterine bleeding.	Threatened and habitual abortion, endometriosis.
Dosage Threatened abortion	10 to 30 mg. daily until acute symptoms subside.	50 mg. I. M. daily while symptoms are present, followed by 50 mg. weekly through 1st trimester, or until fetal viability is evident.
Habitual abortion		
1st trim.	10 mg. daily.	50 mg. I.M. weekly.
2nd trim.	20 mg. daily.	100 mg. I.M. q. 2 wks.
3rd trim.	40 mg. daily, through 8th month.	100 mg. I.M. q. 2 wks. through 8th month.
Supplied:	2.5 mg. scored, pink tablets, bottles of 25; 10 mg. scored, white tablets, bottles of 25 and 100.	Sterile aqueous suspension for intramuscular use only. 50 mg. per cc., in 1 cc. and 5 cc. vials.†

Precautions: Clinically, Provera is well tolerated. No significant untoward effects have been reported. Animal studies show that Provera possesses adrenocorticoid-like activity. While such adrenocorticoid action has not been observed in human subjects, patients receiving large doses of Provera continuously for prolonged periods should be observed closely. Likewise, large doses of Provera have been found to produce some instances of female fetal masculinization in animals. Although this has not occurred in human beings, the possibility of such an effect, particularly with large doses over a long period of time, should be considered.

Provera, administered alone or in combination with estrogens, should not be employed in patients with abnormal uterine bleeding until a definite diagnosis has been established and the possibility of genital malignancy has been eliminated.

†Each cc. of Depo-Provera contains: Medroxyprogesterone acetate, 50 mg.; Polyethylene glycol 4000, 28.8 mg.; Polysorbate 80, 1.92 mg.; Sodium chloride, 8.65 mg.; Methylparaben, 1.73 mg.; Propylparaben, 0.19 mg.; Water for injection, q.s.

The Upjohn Company, Kalamazoo, Michigan

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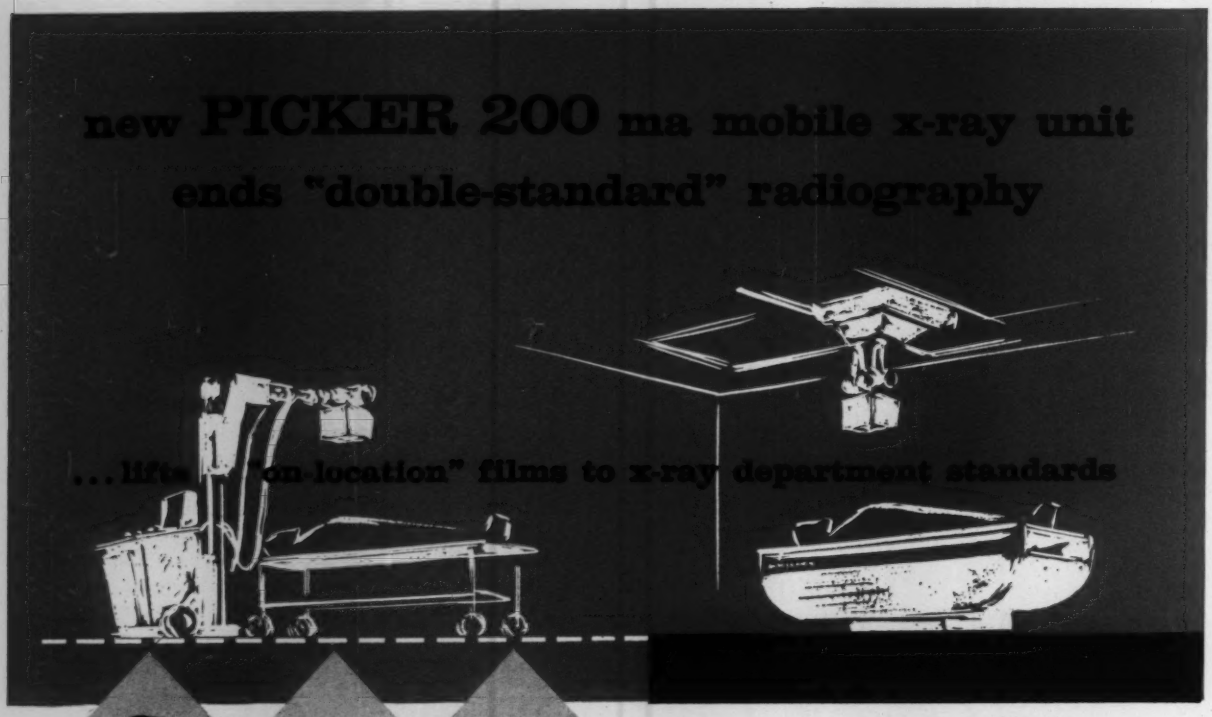

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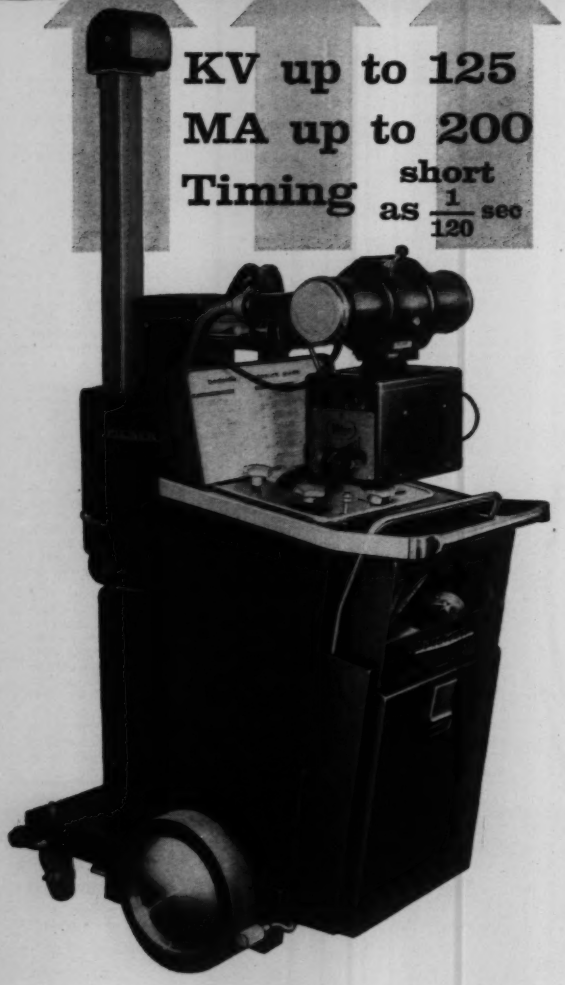

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service from headquarters

Holding auxilians' interest

Our hospital auxiliary has been organized for many years and has sponsored many worthwhile projects. In recent months, however, leaders of the group have begun to feel that the interest and enthusiasm of the members is not what it could be. We would like suggestions on what could de done to strengthen the motivations of the auxiliary members and renew their spirit of service to the hospital.

Perhaps a good way for you to go about creating more interest would be through planning for an orientation course—or perhaps it might be called a refresher course—for auxiliary members who are giving volunteer service in the hospital and those who are active in some of your projects. If only a few members have been active in some of the auxiliary services, such an orientation course might be effective in enlarging the group of members serving in one way or another in the projects of the auxiliary.

Sometimes it is difficult to hold the interest of members because they see their work only in fragments, and they have difficulty in relating these fragments to a total service picture. For example, the auxiliary members who do mending and sewing for the hospital may need to be reminded of the value of this work from the viewpoint of the patient, the medical staff and the hospital employees who benefit from it. It might be helpful for them to see how their particular activity fits into the larger pattern so that they can see the importance of the tasks they perform.

If your auxiliary operates a gift shop and snack bar, orientation for the volunteers who are staffing these operations can include not only an explanation of their duties and responsibilities within the shop, but also something about the effect their service has on everyone within the hospital. This additional orientation will help these volunteers to see their activities in the shops in perspective with the rest of the hospital service as well as the over-all auxiliary operation.

Activities offered to auxiliary members should be geared first to the needs of the hospital as expressed by administration. Activities should be geared to the potential of the auxiliary itself to furnish the manpower for these needs, for there is no point in setting up a service which demands 50 members if only 10 members can take part. Also, the selection and placement of auxiliary members in the services should depend upon their abilities to fit into the activities.

Another way to stimulate interest and participation among the auxiliary members is through the general business meetings held each month. These meetings may be used to focus general interest throughout the membership on the project and activities of the auxiliary. New projects to be undertaken by the hospital auxiliary should be the subject of discussions between the auxiliary president and the hospital administrator.

—GERMAINE FEBROW

Hospital purchasing service

Our hospital and other hospitals in this area have been receiving promotional mailings from an organization known as the United States Hospital Purchasing Association, Inc. This firm is offering a group purchase plan for hospital subscribers. We would like any information you may have on the experience and reputation of this firm.

The United States Hospital Purchasing Association, Inc., is a new corporation with headquarters in Chicago. Promotional mailings have been distributed by the firm to many hospitals throughout the country.

The method of operation is for the participating hospital to send its order directly to the purchasing association, which in turn will select a regional or local supplier to fill the order. The supplier then bills the hospital directly. It has been stated that for items pur-

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

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chased in this manner, the hospital will be charged not less than 10 per cent below the advertised price of the articles as they appear in the supplier's catalogue. The purchasing association plans to send to participating hospitals a monthly bulletin informing them of special purchase opportunities.

The company expects to operate on membership fees paid by participating hospitals. Any operating deficits are expected to be underwritten by the suppliers with which the company cooperates.

Because this for-profit corporation was organized only in January of this year, it has no substantial period of experience and, therefore, there are no participating hospitals which have been able to comment on whether they are satisfied with the service.

—SAMUEL WHITE JR.

PHS institutional grants

What is the status of the new Institutional Grants program enacted by Congress last summer as an amendment to the Public Health Service Act?

The U.S. Public Health Service is receiving queries and applications under this program, but as yet no grants have been made. Specific requests should be addressed to the Division of Research Grants, National Institutes of Health, Bethesda, Md. The division will send pertinent material and answer specific questions.

This program is being called the Institutional Grants program rather than Institutional Research Grants program to distinguish it from the PHS Research Center Grants Program. Under the latter, grants are provided for setting up a research resource (PHS prefers the use of "resource" rather than "facility" to make it clear that these grants do not cover construction).

The Institutional Grants program is designed to provide a lump sum to an institution for use as its officials see fit for the support of research and research training.

—KENNETH WILLIAMSON

Housekeeping by contract

What are the advantages and disadvantages of contracting for hospital housekeeping services?

Although we do not have information which will enable us to answer this question in full, reports which we have received indicate that contract service is worthy of consideration in any hospital where departmental operations are at a low level of efficiency. The possibility here is that an outside contract firm can, by improving the operation of the specific department, render a better service at no greater cost. This, of course, presupposes that the hospital has not attempted to improve the efficiency of the department and that there is no one on the hospital staff with enough time or training to bring the department up to a high level of efficiency.

It would appear that better service would be obtained from contract firms if they understood that they had the total responsibility for housekeeping. It would be advisable to spell out exactly what is expected of the contract firm in the contract drawn up be-

(Continued on page 103)

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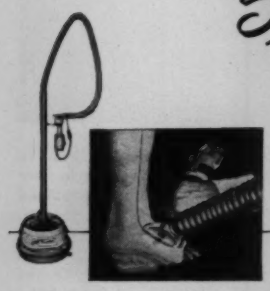

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2. **Hospital offers** each new mother, before discharge, a 24-hour supply of formula. It is given to her in a Davol Handy Rack with 6 Feed-Rite Nursers, for the regular retail price of the Nursers alone.
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DAVOL Feed-Rite Plastic Nursers		
PLAN 274P Feed-Rite Plastic Nurser, with Nipple Cover	$1.65	$2.65
PLAN 254P Feed-Rite Plastic Nurser, with Seal	$1.45	$2.35

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HOSPITALS

...CIATION

editorial notes

—babies and breadwinners

THIS IS an appeal to readers of HOSPITALS, J.A.H.A. to help prevent polio epidemics in 1961. You can do so by making sure that the people you serve understand that:

- Oral vaccines will not be available until after the 1961 polio season.
- Four doses of Salk vaccine give 90 per cent, or better, protection.
- Those who have had no vaccine can get minimal protection before summer with three injections of Salk vaccine, spaced two weeks apart.*

The Surgeon General's Committee on Poliomyelitis Control, whose members include representatives of the American Hospital Association, the American Medical Association, the National Foundation and various other health and medical organizations as well as citizen groups, have endorsed the proposal of "Babies and Breadwinners" drives in communities throughout the nation.

The slogan "Babies and Breadwinners" was chosen because it sums up the current vaccination problem. Babies, i.e., children under five years of age, have accounted for almost half of all paralytic polio cases for the past several seasons. There are eight million children in this age group who have not even had the minimum of three injections, and half of them have had no vaccine at all.

Hospital personnel have a particularly good opportunity to impress upon the mothers of newborns the importance of starting the baby on his schedule of injections at two to four months of age. All babies should have at least three of their four injections by the time they are one year old, but only 8 per cent of the babies born a year ago have had three injections. Almost half, 48 per cent, have had no vaccine at all.

Technical consultants to the advisory committee have stated that, if 85 per cent of the children under five years of age in low income families could be vaccinated before next summer, there would be virtually no danger of any community experiencing an epidemic in 1961.

This view is substantiated by the fact that almost all epidemics in the five seasons that vaccine has been available have started in low income neighborhoods and among preschool children.

Surveys show that, despite these tragic lessons, the low income areas of almost every community continue to contain thousands of children who have had no polio vaccine. An epidemic could start in any one of these areas at any time. Promoting vaccination in such neighborhoods is the particular goal of the "Babies and Breadwinners" drive. Promotional material will stress this theme in car cards, radio and television programs and in magazine and newspaper advertisements.

However, it is generally agreed that to reach many low income families, personal appeals are necessary. For this reason, in addition to the advertising campaign, the Public Health Service has prepared a how-to-do-it booklet for health and other community leaders which outlines methods of organizing special drives in low income neighborhoods.

Breadwinners, particularly fathers, are the second most vulnerable group because so many of them have not yet been vaccinated. Every summer, tragic cases occur of the father and sole support of a large family of children being stricken with polio. In adults, the disease is especially serious, frequently resulting in death or extensive, permanent paralysis. At present, 52 per cent of men in the highly vulnerable age group of 20 to 40 have had no vaccine and 63 per cent lack the minimum protection of three doses.

The record of women in this age group is somewhat better—52 per cent are adequately protected—but not good enough. Although it is well known that pregnant women run great risk if they are not vaccinated, there are still women who go through pregnancy without the protection of the polio vaccine.

As a second line of defense against polio epidemics this summer, the Public Health Service has requested funds to purchase oral vaccine, if any becomes available, which would be rushed to the scene of a potential epidemic. Possibly this could be given to enough people, fast enough, to stop an epidemic at an early stage. At present, however, this is merely a hope and an untested theory.

The only certain way to prevent 1961 polio epidemics is to get more widespread use of the Salk vaccine—promptly. LUTHER L. TERRY, M.D., *Surgeon General, U.S. Public Health Service.*

*This is advocated only because there will not be time to follow the normal schedule which is: two doses spaced two weeks or a month apart, a third dose seven months later and a fourth a year later.

HOW HOSPITALS AND NURSING HOMES CAN WORK TOGETHER

by ROBERT MORRIS

Nursing homes have reached such proportions that it is necessary to examine the feasibility of integrating them more fully with other health and medical care groups, the author states. Studies of 10 examples of close cooperation between nursing homes and community hospitals indicate that successful integration can be achieved with advantages to each institution.

IN RECENT years, the efficient provision of adequate and comprehensive medical care has been complicated by a growing dependence upon a variety of services and institutions which are not administered or directed by the medical profession. Nursing homes, both proprietary and nonprofit, have grown so rapidly in importance that they now constitute a major factor in planning health care, either as a resource or as an alternative to hospital care.

During the past two decades, the number of nursing home beds has risen to more than 450,000 and now approximates the number of general hospital beds in the United States. This rapid growth has been accepted with some reluctance by the health serving professions which are rightly skeptical about the adequacy of care provided in institutions not under close medical or hospital supervision. However, this cannot obscure the fact that these institutions have become essential for the care of many sick persons in the United States, although they have not yet become an integral part of our system of medical organization.

Robert Morris is associate professor of community organization, The Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass. He initiated and is consultant to the large-scale study from which this report is drawn.

This situation is readily understood in light of the great pressures exerted upon our health services, namely: (1) increased demand for health and medical care of all kinds; (2) the improved ability of patients to pay for care through spread of prepayment insurance; (3) the problem of the aged and the increase in long-term or chronic illnesses; (4) scientific advances in medicine; and (5) the shortages of manpower. One result has been the search for new means to care for those patients not sufficiently sick or disabled to require a hospital but too sick to return to their own homes. It is for this group of patients that nursing homes have become so important.

Nursing homes have now reached such proportions in their growth that it is necessary to examine how they can be incorporated into the major stream of health and medical care organization. One possible approach is through close

—a report of 10 successful programs of professional and administrative cooperation

cooperation with general or community hospitals. This approach has many attractions, in theory at least, for the hospital. It offers some promise of relieving the pressure for more and more hospital beds, of smoothing the discharge of certain categories of patients and of assuring better continuity between the hospital and post-hospital phases of treatment.

The feasibility of this approach was recently studied as one part of a larger inquiry into the coordination of health services for patients with long-term illnesses.* An examination was made of the relationships already developed between voluntary general hospitals and nonprofit institutions for long-term care. Ten cases of either close cooperation or integration of services between hospitals and nursing homes were studied in New York, Chicago, Philadelphia, St. Louis, Toronto, Cincinnati, Baltimore and Troy, N.Y.

Programs were selected in which the current pattern of cooperation went well beyond the traditional methods of informal referral of patients and exchange of information between the two institutions. In each case, there was some pooling of staff, facilities, or services between the two independent institutions.

The eight general hospitals in the study each served the general community on a nonsectarian basis, although seven of them were organized under Jewish community auspices. The 10 long-term institutions studied included seven homes for the aged or the chronically ill, each with extensive and comparable nursing provisions for chronically sick bed-patients. These institutions differed primarily in the age limitations fixed for admission and in the added services for ambulatory aged conducted by the homes for aged. They all provided nursing care and minimum rehabilitation under some medical supervision. Three institutions were classified as chronic disease hospitals but were included in the study because their patients and services were similar to those found in the seven nursing home type institutions. The chronic disease hospitals differed primarily in more extensive medical control and a higher rate of turnover in bed occupancy.

These 10 homes* share several characteristics with other nonprofit and proprietary nursing homes: high proportion of patients over 65 years of age; a predominant majority of residents dependent upon some public or private assistance and unable to purchase private medical care; and service built upon nursing and custodial care under some medical supervision.

The conclusions about these nonprofit homes may be applicable to many other types of nursing homes, including the proprietary ones. Although all of these nursing institutions are under Jewish community auspices, four of them serve the entire community under nonsectarian admission policies.

Analysis of the relationship between the hospitals and nursing homes studied indicates that there is no technical bar to close cooperation between a hospital and a nursing home. In fact, certain advantages accrue to each. These conclusions can be drawn:

1. It is possible for a hospital and a nursing home to integrate professional services without merger and without loss of basic autonomy.

2. Substantial integration of physicians and diagnostic services can be achieved. Joint selection or appointment of key medical staff for the nursing home is a favored and effective practice.

3. Other administrative and professional integration is limited. Successful examples in nursing and rehabilitation suggest that integration can be extended.

4. Free movement of patients between institutions has not yet been achieved. Hospitals generally admit home patients on a priority basis, although the number is small in any month.

5. Substantial benefits have been derived by long-stay institutions in the form of upgrading internal services, ready access to hospital facilities and greater capacity to treat and care for chronically ill patients.

6. Although direct benefits to co-

*This study was sponsored by the Council of Jewish Federations and Welfare Funds (project director, Franz Goldmann, M.D.) and supported by a grant from the U.S. Public Health Service, Division of Hospital and Medical Facilities.

*The generic term "home" is used to denote the three types of long-term institutions included in this study.

operating hospitals have been minimal, future benefits are anticipated in teaching, research and more rapid discharge of chronically ill patients.

7. Participating homes and hospitals are generally satisfied with their experiments.

INTEGRATING PHYSICIANS' SERVICES

In 9 of the 10 cases studied, integration of physicians' services was found to be the most advanced of all professional relationships. The form and intensity of integration varied, but a major characteristic was the assumption of responsibility for the medical program at a home or chronic disease institution by the medical staff of the cooperating hospital.

This responsibility was usually discharged through the joint selection of a medical director for the long-term institution, provision for consulting and attending staffs and arrangements for x-ray and clinical laboratory services. These arrangements constituted a major change for the homes that had previously relied for medical guidance upon the volunteer time of physicians who did not necessarily have any responsibility to a major medical institution. Today, medical leadership in these homes is compensated for its time and is responsible organizationally to a major hospital.

In 7 out of the 10 cases, the medical director of the home is recommended by the medical staff of the hospital and is appointed by the home, which pays his salary directly. These physicians have previously held prominent positions on the medical staff of the hospital and have shown unusual interest in care of the chronically ill. The procedure for nomination usually takes place quite informally through exchange of views between the directors and leadership of the two institutions. In only one case is it formalized by discussion and action by the hospital board of trustees.

The medical director is fully responsible for the home medical service and for the supervision of other physicians, nurses and related staff. He sets standards of practice and is responsible for direct medical care to patients who do not have their own physicians.

When the medical director of the home is a senior physician with long years of practice, he seldom carries major responsibility for treatment. Instead, this is delegated to a younger physician who receives part-time compensation for his services.

In three cases studied, the medical director is required to report regularly to the medical staff of the hospital that nominated him. More often, the medical directors of the homes are free of hospital control in the exercise of professional judgment. Communication with hospital administration is usually at their initiative. They continue, however, as part of the hospitals' basic medical organization and as members of the attending staffs. They are, therefore, involved in a complex of associations which lead to a widening network of integration.

ACCESS TO CONSULTANTS

The clearest example of informal widening cooperation is the use of consultants who are drawn from the base hospital through the initiative of the medical director. In two cases in the study, the chiefs of major hospital medical services agreed to assign their staffs to rotating panels with responsibility for consultation and for patients who did not have their own physicians.

These panels are responsible to both their hospital department heads and to the medical director at the home. The panel members are expected to make rounds at regular intervals, usually once a week. In other examples of integrated services, panels are selected by the home medical director and visit the institution for special purposes upon the request or invitation of the medical director.

In four instances, the hospital medical organization also has recommended specialists (surgeon, psychiatrist, roentgenologist, etc.) whom the home has retained on a consulting basis. In the characteristic situation, these retained specialists visit the home once or twice a week.

In the majority of the institutions, under study, consultants contributed their time as a community service, or as a partial fulfillment of their obligation to the hospital to give time to ward and outpatient care. In four cases, the home reimbursed the consultants for each visit, or gave them an annual retainer.

Four hospitals in the study employ and assign resident physicians to the homes. These physicians serve between two and four months under the supervision of their hospital department chiefs and the medical director of the home. These assignments are not yet approved as teaching residencies, but the home medical staff is responsible for teaching rounds and conferences on chronic diseases. In three of these cases, the home pays the hospital for the assigned time of a resident physician.

The rotation of hospital resident physicians has proven more complicating than expected. The homes are not accredited for residency training, and the medical staffs of hospitals seldom consider the homes' patients as appropriate for teaching purposes. The limited number of medical and surgical residents in hospitals also is a factor sharpening the competition for physician services.

These obstacles have been approached in several ways. In one, a premium salary is offered; in others, the medical director has been able to develop sufficiently stimulating teaching programs in geriatric medicine. However, the assignment of resident physicians is largely dependent upon hospital leadership determined to use its resident staff for these purposes.

REHABILITATION SERVICES

In five cases, the hospital and home have a common chief of physical medicine or rehabilitation and share his salary. He supervises physical therapy and occupational therapy programs at the home and is responsible for developing as much of a rehabilitation service as the patient load warrants. The emphasis is upon providing maximum medical guidance to the homes as they develop their own rehabilitation plans suitable for a nursing or long-term institution.

There is very little exchange between the physical therapy and

occupational therapy staffs of the two types of institutions, and only limited transfer of patients for rehabilitation. Several reasons for this have been advanced:

The rehabilitation programs of each institution are limited and geared to different goals—short-term treatment in an acute hospital, and prolonged treatment in a home. Often, there are different levels of recognition about rehabilitation potentials in each institution. Some hospitals with a vigorous program may be associated with a home that has little appreciation of this new field. Conversely, a few dynamic homes have developed rehabilitation services well ahead of the hospital. Differences in the patient characteristics of each institution may alter the real need each has for such specialized services. Furthermore, the therapeutic and technical staffs are always employed separately so that there is no natural opportunity for interchange. Finally, distance between institutions hampers frequent movement of patients for short periods of therapy.

PHYSICIANS' TIME

Detailed data on the time physicians devote to these homes are not available, but limited observation confirms results obtained in other studies.** Several patterns have been observed. In three of the cases studied, the homes employ an average of one full-time physician, including the medical director, per 100 beds.‡ In addition, attending, visiting and consulting physicians provide between seven hours per week per 100 beds in the case of a long-term nursing institution to 64 hours per week per 100 beds in a chronic disease hospital.

In one chronic disease institution of 87 beds, all medical services are the responsibility of the cooperating general hospital. There is no full-time staff, but three or four physicians visit daily. In addition, the medical director spends a minimum of two hours daily at the institution, and consultants are called in regularly.

At the other extreme of intensity, a home of 163 beds has its medical director visit half days twice a week for clinics and general supervision, although he is available for emergencies. In addition, a surgeon and a psychiatrist visit the institution at least twice a week. Approximately 30 hours of physicians' time is reported for each 100 beds each week.

No generally accepted standards exist by which to measure the adequacy of these amounts of time. The local staffs have expressed satisfaction, except for the promptness with which consulting or visiting physicians have responded to calls. Admitting policies, levels of disability served in the homes and individual standards of performance all affect the amount of time required.

Hospitals originally expected to collaborate on research in chronic diseases with the homes, but only a few projects have been initiated. In one case, the two institutions jointly sponsor major research in rehabilitation for the geriatric patient. In another, a research program for case finding and control of diabetes has been launched at a home under the clinical staff of the hospital, and some patient surveys have been conducted for special diseases. Individual home physicians have initiated private studies on problems especially interesting to them, but controlled and systematic studies are still the exception.

Despite this limited experience, the leadership of both hospitals and homes expect to develop more joint research by bringing hospital scientific skill to the long-term patients in nursing institutions.

SHARING LABORATORY SERVICES

A further illustration of the widening cooperation between hospitals and homes is the extent to which hospitals provide x-ray and clinical laboratory services to the homes. Six of the homes maintain laboratory facilities for diagnostic tests but appoint as x-ray or laboratory director the physician who holds the same position at the cooperating hospital. The roentgenologist and pathologist conduct complex studies in the home or at the hospital at the request of the patient's physician, the medical director or the consulting staff. They also supervise technicians employed by the home. In four cases, the homes provide only for those minimal laboratory procedures commonly performed in the office of a general practitioner. All other laboratory and x-ray work is done at the cooperating hospital on request of the home medical staff. These laboratories and their staffs are, in effect, common services for both institutions

The volume of x-ray and laboratory services provided by hospitals to homes varies according to the extensiveness of home facilities. This, in turn, reflects the development of its medical program. In all cases for which separate records were kept, the volume was found to be small. In two institutions with bed capacities of 100 and 150, the hospital has provided an average of between 50 and 60 laboratory units of work a month. In a third institution, the laboratory technician of a home is supervised by the pathologist of the hospital and is responsible for 17,000 laboratory units of work a year; only 300 of these units are performed at the hospital.

The volume of diagnostic work appears to have increased under the integrated program, but not to troublesome proportions. It is not yet possible to predict whether further interest will seriously increase the demand for such diagnostic services.

The homes' directors of laboratory and roentgenology are treated as other physicians and are paid an annual retainer fee, or by the visit. Hospital technicians from the hospital are paid by the hospital, which is reimbursed by the home. Homes reimburse hospitals for studies conducted in hospital laboratories, usually at cost exclusive of administrative overhead.

Formal arrangements for coor-

**Preliminary reports—(I) *Organization of Personal Health Services in Homes for the Aged*, (II) *Residents of Homes for the Aged: Their Health Conditions and Health Needs*, and (V) *Chronic Disease Hospitals and Related Institutions*—from the Study of Coordination of Health Services for Patients with Long-Term Illness, Council of Jewish Federations and Welfare Funds, Inc.

‡Institutions with 95, 230 and 319 beds with one, three and four full-time physicians, respectively.

dination between other professional and administrative staffs are minimal and scattered. For example, in three cases, hospitals recommended and helped homes obtain competent directors of nursing. Once these persons were appointed, relationships between the nursing departments became informal and "ad hoc". There is no regular arrangement for exchange of experience or information. The fact that three nursing supervisors at homes originally came from the hospital has served as a strong unifying element. The nursing department, in each of these cases has stressed the ease with which information is exchanged on individual patients and the over-all sense of community that seems to govern their relationships.

The nursing directors in homes, however, commented on the weakness or lack of professional interchange. They report the development of certain nursing procedures especially effective with long-term patients that have not yet been translated for general hospital use. On the other hand, physicians at homes often report that they do not find nursing quality to which they are accustomed in hospitals.

The advantages of more exchange of nursing experience and practice have been realized by nursing staffs, and a few steps have been taken to bring them about. For example, in Philadelphia, the home nursing director is also associate director of nurses for the hospital. She is employed by the hospital for the home, subject to the latter's approval. She is fully integrated in the total hospital operation and is chairman of the hospital's nurse education committee. Nursing school students are assigned to the home for brief periods of training.

A more common situation is one in which the nursing staffs have only limited knowledge of the partner institution. The directors of nursing seldom, if ever, visit the other institution. In at least two cases, efforts to initiate a liaison in the form of joint nurse conferences failed. The nursing departments have had no natural and functional contact with each other and have not developed a mutual understanding or interest sufficient to work together.

There was only one example of integrated purchase of supplies where virtually all supplies, including drugs, linens, food and equipment were ordered by the hospital purchasing agent for the home.

In a few cases, experiments in joint purchasing were attempted and discontinued. Data on the advantages and disadvantages are not conclusive, but a number of problems have been identified. The buying needs of the two institutions are dissimilar in some respects. Requirements for drugs and equipment vary so much that there is less bulk purchasing of common items than would be expected. Specifications for items vary, and there is no mechanism to evaluate whether they can be unified. Furthermore, the volume of purchases for two institutions rather than one is often not sufficiently greater to result in major savings. Certain savings are hard to share: for example, the large free sample supplies a hospital acquires. Finally, boards of trustees of nonprofit homes can use their business connections to effect considerable savings, comparable to those possible by joint purchasing. Where this is true, separate purchasing means greater administrative freedom and flexibility as well as comparable dollar savings for the home.

For some or all of these reasons, homes have tended to seek their own buying channels. This trend has been accelerated by a variety of complaints about joint purchasing efforts, slowness in filling the homes' orders—which encouraged a feeling of "second class" treatment—and rigidity in meeting variations in specifications. At this time, no clear advantage has been demonstrated for joint purchasing.

In three cases, the hospital does all the laundry for the cooperating institution at substantially less than the prevailing commercial rate. In a fourth case, the hospital is preparing to offer the same arrangement to the cooperating home. In these cases, the hospital laundry facilities were not fully utilized. Under such circumstances, unified laundry service seems to be mutually advantageous.

EFFECT OF COOPERATION

A major characteristic of these integrated programs is the interagency agreement governing admission or transfer of each institution's patients. These agreements are usually made to (1) assure home patients ready access to a hospital bed and (2) facilitate discharge of certain long-term hospital patients. The first of these goals has been well achieved; the second has been achieved only to a limited extent. There was one unanticipated result; namely, a reduction in transfers from homes to hospitals, which coincided with an improvement in home resources.

In nine cases, the hospital has undertaken to give priority admission to wards to home patients without their own physician and to furnish outpatient care. These patients are returned to the home promptly when the medical staff so decides. The hospitals consider this assurance of prompt discharge although it is limited to selected patients.

The number of patients transferred from the homes is still small in relation to the total hospital admissions, but it represents a significant proportion of the home resident population. From seven homes with bed capacities ranging from 72 to 267, not more than three or four residents were transferred to hospitals in an average month. However, over a year's time, these monthly hospital transfers amounted to between 5 per cent and 22 per cent of the homes' total populations. An average of approximately 10 per cent of a home's population is estimated to need general hospital care during a year. This estimate is supported by a six-month study of 530 residents in five homes for the aged.*

In the opinion of the administrative and medical staffs of the homes, the low volume of transfers from home to hospital can be partly attributed to the significant increase and improvement in nursing

(Continued on page 104)

*Goldmann, F., Residents of Homes for the Aged: Their Health Conditions and Health Needs. Preliminary Report II (See footnote, p. 39).

CONSTANT care for tonsillectomy and adnoidectomy patients at the Long Island Jewish Hospital, New Hyde Park, N.Y., starts at 9 a.m., when the youngsters and their parents are greeted by a volunteer in the hospital lobby. "T & A" patients are admitted in groups of eight each Tuesday and Thursday.

A constant care program for 'T&A' patients

by MARTIN SAREN and HERBERT ABRAMSON

TWO AT a time, the children are taken to examining rooms in the emergency suite, where a pediatric resident examines throat, ears and chest and the volunteer checks weight, temperature and morning food intake.

(CONTINUED)

A program for providing continuous care and supervision for "T & A" patients not only lessens the trauma of a strange new experience for the children but also brings peace of mind to parents, the authors report. They describe the program in detail, noting that the hospital also benefits through increased efficiency and strengthened good will of physicians and the public.

TO FOSTER a feeling of security in parents and in children admitted for tonsillectomy and adenoidectomy procedures, and at the same time give the best possible care, is the primary goal of a program at the Long Island Jewish Hospital, New Hyde Park, N.Y. A second objective is to provide an efficient and workable procedure for both hospital personnel and staff physicians.

For most "T & A" patients, this

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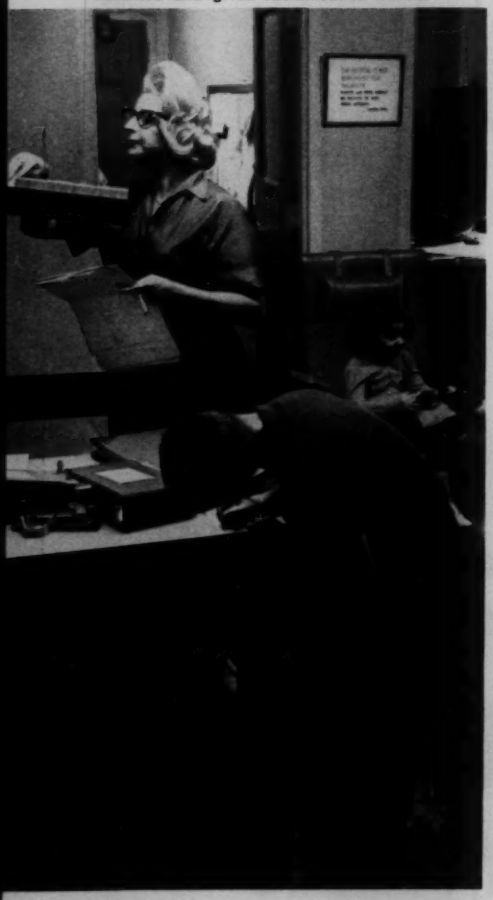
FORMAL hospital procedures over for the moment, the patients enjoy a "get-acquainted" period in the playroom on the pediatric floor, where their play is supervised by a volunteer and some of the parents.

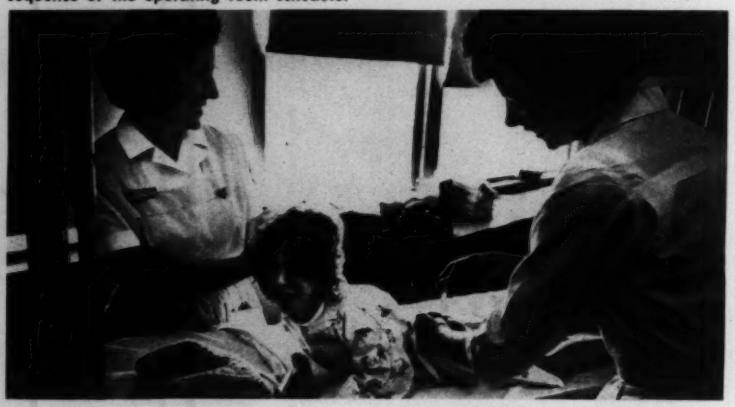
ACCOMPANIED by their parents, the youngsters go next to the "T & A" room, a large bright room containing eight five-foot cribs which have been tagged previously with the children's names. Diversion is provided with television, books, games and toys.

DRESSED again, the children proceed to the admitting office, where they are formally admitted and given identification bands.

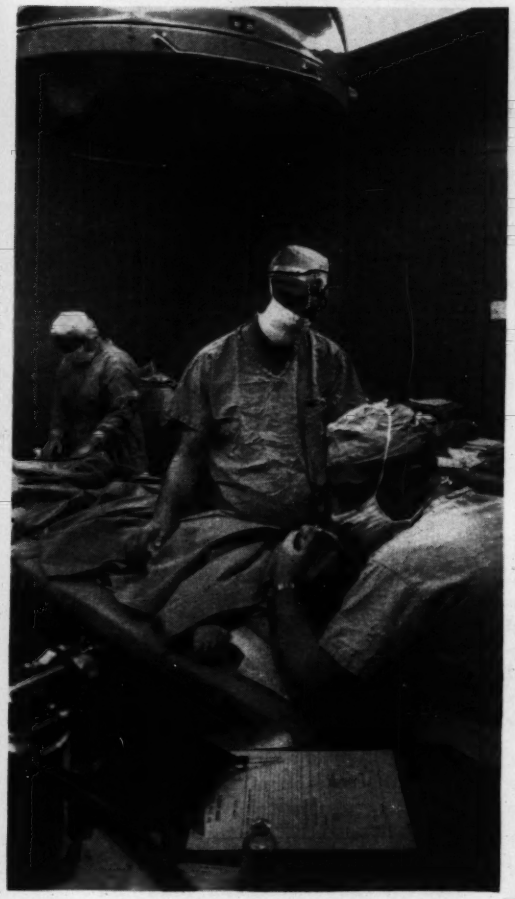


(ABOVE) The parents take their leave after a laboratory technician has collected blood samples and just before the first preoperative medication is given.

(BELOW) Around 11:30 a.m., the nurse on floor duty gives the first child her preoperative medication. Other children receive medication at 20-minute intervals, following the sequence of the operating room schedule.



ONE BY ONE the children are wheeled in their cribs to the operating suite. The volunteer remains in the "T & A" room the entire time.



IMMEDIATELY after surgery, the children are returned to their own cribs in the recovery room. There they remain as a group, the recovery room nurse carefully checking the condition of each, until all can be safely moved back to the "T & A" room. Parents are not allowed to visit the children during the evening, but they can view them unobserved through the glass panel of the door. A nurse is present in the room throughout the night.

(BELOW) Parents arrive at the hospital next morning as discharge examinations are in progress. They are given instructions and physicians' prescriptions by a nurse, and an aide accompanies parents and children back to the lobby.

overnight stay is their first hospital experience; they are understandably apprehensive and fearful. The same holds true, perhaps in even greater measure, for parents. In evaluating the prerequisites of a successful "T & A" program some four years ago, our primary concern was, "What can administration do to allay the anxieties of parent and child? What specific steps can we take to make this short hospital stay as free from fear as possible?"

The success of a surgical procedure frequently depends upon the quality of postsurgical nursing

(Continued on page 55)

A METHODS IMPROVEMENT CASE STUDY

Four departments, one aim:

FIND A BETTER WAY

by CARL F. THIELMANN

Study and analysis of four departments—admitting, x-ray, housekeeping and surgery—made during a methods improvement program showed that the same basic industrial engineering tools can be applied to individual departments and that concrete results can be obtained in each, the author states.

THE HEALTH field differs from industry in many ways, but there are many similarities. The hospital is subjected to the same economic fluctuations that characterize business activity. It is keyed to the economic status of the community and to the psychological and sociological attitudes of the people it serves. The hospital must compete for land, labor, capital and managerial ability, and it is susceptible to the dislocations of technological change. The hospital manufactures no product, yet a large general hospital does considerable processing and fabricating in its various departments. The typical hospital has many routine, repetitive procedures which have more production line characteristics than many industrial jobshops.

HOSPITAL METHODS IMPROVEMENT

The problem of establishing a methods improvement program in a hospital is dependent upon the attitude that exists in the hospital. Enlightened management in all fields recognizes that programs affecting or depending upon people must be explained to them in an effort to obtain their support. Techniques for achieving this all important first step vary widely, but almost everyone agrees that without it, the best intended program is doomed to failure. Indoctrination in some of the simpler tools and techniques of industrial engineering has been found to be a powerful means of attaining these goals through education. The proper direction of indoctrination is from the top down. The board of trustees should have a "faith" level; department heads and perhaps the medical staff will need the "appreciation" level. The "understanding" level is required by the administrative staff member who is responsible for the program, and the actual work must be done by technically competent people.

The idea for a planned improvement program at the Toledo (Ohio) Hospital was discussed for several years through all levels of personnel.

Study and analysis was made of the admitting office, the x-ray department, housekeeping and surgery. In addition, data were gathered on other areas indirectly related to these departments. Trouble-shooting studies were made to solve localized problems that needed technical data for prompt analysis. The same basic approach was used on each project and each individual problem in the project.

METHODS AND TOOLS

A production study begins by acute observation in the specific department by a trained expert for long periods of uninterrupted time. Every type of activity carried on during the work day is carefully watched. After determining the various activities, how they occur and how they are performed, the engineer makes time studies of each job to determine what per cent of the total day is devoted to a particular activity. After these

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data are accumulated, two questions can be asked: Is the job really necessary? If it is, will further study of this activity reduce costs or improve patient care?

If the answer to these questions is "yes", then a study of the contents of the job is done to determine how it can be performed more easily, or with less materials, or in less time. Some of the techniques used to help analyze the job are flow process charts and value analysis. A flow process chart is a systematic presentation of each phase of a job as it occurs and shows the relation between each succeeding operation. It points up the areas where improvement can be made. Value analysis is simply comparing various types of materials or supplies against each other to find the one that does the best job for the least cost.

After this phase of the analysis, a review of the time studies is made to determine any areas where excessive time was spent on particular tasks. Each activity that involves extended physical exertion is reviewed. By applying layout techniques, a better arrangement of the physical work area can be made.

Another procedure that is helpful in work simplification is the combining of several activities from different jobs to utilize personnel better and distribute the work load more evenly.

The final tool employed is common sense—instructing people how to do what is most sensible. This may sound trite, but it is surprising to find how many practices are conducted in hospitals that are useless and defy an explanation of origin and purpose. In the Toledo Hospital, these methods and tools were applied to the program of hospital improvement.

A STARTING POINT

The admitting office was selected as a starting point for the Toledo Hospital program. The purpose of this particular study was to improve the service to the incoming patient; to reduce the time he waited to be admitted, and to reduce the number of incidents of assigning patients to private rooms that they did not select. (This happens when beds are scarce.)

Since admitting is a 24-hour job, studies were made on the three shifts over a period of 16 days. Five days were spent on the 7 a.m. to 3 p.m. shift; six days were spent on the 3 p.m. to 11 p.m. shift, and five days were spent on the 11 p.m. to 7 a.m. shift.

During this period, the number of patients admitted and the time needed to make the admission were recorded. The occurrence of each event and the time that it occurred were listed in sequence. Later, the blocks of time for each identical activity were added together to establish the amount of time they contributed to the total work day. This helped determine which activities needed concentrated effort for improvement. Those activities that took the most effort and time were analyzed further.

One example of this was the typing of small index cards used in the admitting office and also at the information desk and chaplain's office. These index cards were typed in triplicate for each patient admitted. The typing took up a significant percentage of the total day. Closer study of this activity disclosed that the design of the form and the use of the form required placing it in the typewriter twice to completely type all the information. Analysis indicated that a new form could be substituted that not only eliminated the double work, but also cost less than the old form. The result—a saving of 30 minutes per day and several cents per form.

The time studies taken showed a low utilization of personnel in the morning and an overutilization of personnel in the afternoon. This accounted for patients having to wait long periods of time before being admitted in the afternoon. An analysis of each admitting clerk's work schedule by day and hour and of patient load by day and hour showed poor correlation between the maximum number of personnel on duty at any one time and the maximum number of patient admissions at any one time. The work hours and days of the personnel were rearranged so that the maximum number of people were working when the maximum number of patients were admitted. In addition, thorough investigation of this facet of the work of the admitting office showed that a reduction in total labor hours could be made and still give proper coverage.

REDUCING INCOME LOSSES

The one problem in admitting that was already known simply needed more concentrated analysis. This was the task of reducing income losses caused by placing patients in high rate rooms because of lack of space in wards or semiprivate rooms. Past practice showed that transfer to proper rate rooms was slow because there was no way of knowing who had been misplaced or where.

Constant hunting for a room traffic control board finally brought results. For a small cost, Toledo Hospital obtained a plastic board with multiple-layer rows of removable strips. This permitted the listing of rooms and beds in sequence. As the bed capacity in each department changed along the row, a different color was used to show this. In addition, a different color was employed for each type of room. For example, a private room was indicated by red; a semiprivate room by green. The patient's name and room request were put on a colored ticket—according to code. This was placed in the slot for the room assigned the patient. Colors that did not match were easily seen and indicated immediately that these patients should be transferred to proper accommodations at the first opportunity.

Not all the problems have been solved in this department, but methods improvement is a continuing thing, and each time a department is restudied, new things will be discovered that can be changed.

A FIRST OPPORTUNITY

The study of the x-ray department provided the first opportunity to apply industrial engineering techniques in an area that for the most part is highly technical and employs professional people.

Immediately after the production studies were started, it was

apparent that many activities in the department were repetitive and nontechnical and, therefore, would respond to the procedures described above. Even the technical work took on a form of constant similarity to justify time study and analysis.

Time studies on individual jobs and parts of jobs showed where various operations could be combined and where several positions could be eliminated completely. Further study of these jobs allowed us to improve the remaining operations.

The use of the flow process chart was used to trace the processing of a patient x-ray requisition from the time it got to the department until it was filed. This flow process chart showed that the requisition went through 30 steps to reach its destination. In addition, the chart indicated what type of personnel was performing each step. This allowed us to analyze the distribution of the work load.

Each step of the chart was individually studied to determine its practicality and purpose. By making time studies of various steps and by applying common sense, the number of steps was reduced from 30 to 19.

In the process of reducing the steps in the flow process chart, it was discovered that the whole procedure for reading x-rays and typing reports was a time-consuming job which prevented physicians from giving patients adequate answers or sufficient medical care promptly.

NEW SYSTEM DEVISED

Analysis of the method used showed that a change in (1) the reading of the x-ray, (2) the design of the form used and (3) the filing technique would greatly reduce the time between taking the x-ray and receiving the written report.

Several suggestions were made to improve efficiency. First, the radiologists were asked to dictate all reports into a dictating machine. This was already being done, but only on a limited basis. This would allow the secretary to type reports faster because she would not have to wait for pauses as the physician considered the x-ray. Also, she could pace her work load and do other things while the radiologist read films.

Second, the forms used for the report required carbon insertions. By switching to a different form with carbons already installed, the time spent was reduced in typing each report. Also, the cost of the report form was reduced by $4.25 per thousand because suppliers were asked to submit bids and the hospital picked the lowest one.

Finally, the old system of filing was revised. Originally, the x-ray department copy of the patient report was typed on a 5 by 8-inch file card. Each new report was typed on the same card until it was full. Each time a new report was typed, it meant lining up the card with several 8½ by 11-inch sheets to get a triplicate of the report. By using the new form described above and eliminating the use of the file cards, the x-ray department saved nearly 30 seconds per report in typing time. This reduction gave the secretary more time for additional duties. Time studies on the other jobs in the department made it possible to eliminate an entire position.

PATIENT NUMBER SYSTEM

The installation of a permanent patient number system in the x-ray department caused a need for additional file space. A study of the layout of the room indicated there was space for eight new cabinet sections. By making scale models of the existing equipment, a new layout was arranged which provided space for 32 new cabinet sections.

The largest project in the department was to decide how many technicians were needed. The first step was to make time studies of each type of examination and obtain an average time per examination by type. The second step was to find the number of times each type of examination was done per day. By multiplying the number of examinations by the time per examination, the total time per day was established for taking x-rays. This total time divided by the number of minutes per day indicated how many technicians were needed. From this, a written, formal labor load was established for the department, which meant a reduction in the number of personnel. The reduced load was reached by allowing normal turnover to take place.

The problem of patients waiting to be x-rayed was simply solved by spreading the work load over a full day and utilizing the technicians over a nine-hour period. Originally, most of the work was jammed into the morning. By staggering the work hours of the personnel, it was possible to start earlier, finish later and spread out the patient load.

ANALYZING HOUSEKEEPING ACTIVITIES

The next step in the program was to study the housekeeping department. The problem here was simple. A new addition had been built, and we wanted to find how many more employees were needed to keep the hospital clean.

Production studies, time studies of jobs and parts of jobs and general analysis of activities were undertaken. It was found that the most practical solution to the problem was to do as much of the cleaning at night as possible. Time studies were made of the cleaning steps in all nonpatient areas. These studies were arranged into a formal work schedule that listed specific areas to be cleaned. When the areas on a schedule totaled 480 minutes, this constituted a job for one man each night. All the nonpatient areas in the hospital were subdivided into eight-hour jobs, resulting in eight different jobs. Because this program made individuals responsible for definite assigned areas, it was possible to measure the employee's daily work accomplishment, and it provided better cleaning because each area was definitely covered by someone. The same procedure was used to set up a program in the patient areas on the day shift.

The total result of this study was that twice as much area than previously was covered on a more routine, systematic basis with the addition of only one employee.

Time studies of individual phases of each job indicated that considerable time was spent going to the

janitor's closet in the basement for supplies and a change of water. To eliminate this time-consuming activity, each janitor's closet on the various floors was made self-sufficient. A hose and trough were installed, and supplies were delivered to each janitor's closet by the night supervisor.

DETERGENT WASTE CHECKED

Observations made during the production studies disclosed that no two employees used the same amount of detergent in the water, and that most used too much. The manufacturer's specifications called for a certain dilution for an effective cleaning and germicidal agent. To eliminate waste, a metal measuring stick was designed and made to fit over the edge of the supply cart. When water was filled to this marker, it represented a specific amount that indicated the quantity of detergent to be added. Discarded bottles capable of holding exactly the number of ounces of liquid detergent required were distributed to the janitor's closets. The contents from one bottle, when poured into the carefully measured water, produced the specified dilution to do the best cleaning job. Thus, time and detergent were saved.

One other observation was made while the studies were being conducted. To keep the floors clean, it was necessary to scrub them frequently. The vast flood areas prevented the small crew from scrubbing all the floors. At least six additional employees would be needed if the Toledo Hospital improved the condition of its floors. To make the problem worse, areas of halls had to be closed while the floor was being scrubbed. This hampered visitor traffic and patient transportation. The whole problem was solved by the purchase of a battery-driven, automatic scrub machine. This machine lays down a solution of detergent, scrubs the floor and immediately picks up all the water. With the machine, one operator does the entire hospital floor area twice a week. This consistent scrubbing schedule makes the daily mopping easier and eliminates closed hall areas.

By the time this stage of the program had been reached, the results of the program to date were coming to the attention of other department heads. At the specific request of the chief of surgery, we conducted the next study in the surgical department.

We were asked, "Can we schedule and perform more cases, and if so, will it take more people and how many?" The need to do more cases was based on an increased participation by the staff and the need to get patients to surgery sooner so that their stay would be shortened.

Again, the same basic approach was used to gather the information. Study was made of the routine of the department. Time studies were made on the activities of nursing personnel before and after surgery. A complete analysis of the nurses' work day was made to determine how well they were utilized. Time studies were made on individual facets of the nurses' jobs—their work schedule, what days they had off, and what time they left the department on the day they were to take call. Investigation showed that nurses were working Sundays for eight hours, even though the department was closed.

Records were studied to determine the average length of time it took to perform each type of surgery. This was later used with the information gathered concerning the method of scheduling cases.

The results of the study disclosed the hospital was not getting the full benefit and utilization of the rooms or the personnel in the surgical department because of various practices and policies. A meeting with the chief of surgery and the surgical supervisor quickly altered these conditions.

JUSTIFYING THE LABOR LOAD

To justify a specific labor load, it was established that a scrub nurse and a circulating nurse were needed for each operating room, and one additional nurse was needed for special procedures, such as sigmoidoscopies and cystoscopies. Furthermore, it was determined that one nurse was needed to assist with casts and two nurses were needed for examinations, such as bronchoscopies.

Data from the record study showed that major and minor cases required 1.5 hours to perform; a sigmoidoscopy required 0.25 hours; a bronchoscopy, 0.5 hours; a cast, 0.5 hours, and a cystoscopy, 1.0 hours. By multiplying the hours required by the personnel required, it was easy to establish the man-hours needed for various cases.

A 29-day period that represented the fullest utilization possible of all facilities was taken from the record. The cases of each day were divided into the proper categories, and it was possible to establish the average number per day of each case. This average per day multiplied by the man-hours required for each case established the total average man-hours per day needed to do all the cases.

The result was that it took 13.21 employees per day. The surgical department had 13.50 employees per day working, which meant they were 98 per cent utilized. This answered the question asked by the chief of surgery. More additional people were not needed, even when the rooms were scheduled to capacity.

Changes in policy and more realistic scheduling now allows the department to do 10 more cases per week than previously.

One other study was made in this department. Time studies and production studies were conducted on the aides working in the clean-up rooms. The results of these studies showed poor utilization of the personnel. Two aides in the department were placed in jobs that were vacant from normal turnover. Remaining aides were given additional duties.

The major portion of the Toledo Hospital's program was accomplished by the use of relatively simple industrial engineering tools. Our experience also indicated that any department can be studied and concrete results obtained. However, it is recommended that a program such as this one be started in an area where positive monetary results will be made. This will help "sell" the idea of the need for such a program. ■

LET'S KEEP BACKGROUND

in the background

by RICHARD H. BARRETT, M.D.

The possible benefits to patients and personnel of background music in hospitals are well recognized, but unless the music is carefully programed and controlled and the equipment is properly maintained, it would be better to have no music at all, the author states. He outlines some do's and dont's of background music based on five years of experience at one hospital.

TO THE EDITOR
HOSPITALS, J.A.H.A.

Dear Sir

Enclosed is the article describing the "piped-in" music program at Mary Hitchcock Memorial Hospital and our philosophy regarding it.

Incidentally, I know nothing about music, but I do think that 20 years in the practice of anesthesiology have taught me something about people—especially hospital staff, patients and personnel.

You cannot please all of them. But this much I do know: since we started using background music, over-all tension—especially in our surgical suite—has been markedly reduced and the evidence of frequent fatigue among our personnel is very noticeably reduced as our volume of work has increased.

If various individuals within our hospital were asked to comment on what the effect of music has been, you would hear the following and other statements: "It's nice"; "Can't stand it"; "Why don't you give us some classical music?"; "I wish it were a little more snappy"; "Didn't realize we had music"; etc.

All of this is to say that the casual observer will not be aware of the over-all objective results although he, as an individual, has become a product of the venture.

On true introspection, over a four-year period, there can be no doubt of the good effects of this program, but, I must admit, for the first few weeks the true lovers of classical music may have been a bit unhappy. As soon as they stopped "listening" to the music and began to just "hear" it, however, even they commented with regret on its absence when I have stopped it for various "test periods". The classical music lover might not admit to "an outsider" that he "likes" the background music but I have observed that it has a beneficial effect even on him —an effect of which, I am sure, he is not aware and certainly would not admit freely.

All in all, it has been an interesting and instructive venture.

—RICHARD H. BARRETT, M.D.

* * *

THE VALUE of background music in many kinds of industry is common knowledge. It is well known that this type of music reduces fatigue, lessens absenteeism and increases production with less effort. Also, the quieting effect that music has on some mentally ill patients has been exhibited, and

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MUSIC

music therapy has been employed for several years in psychotherapeutic procedures.

It is difficult to compare a general hospital with a manufacturing institution, an active business office, a steam-filled laundry or a hotel kitchen, where background music may be used. A general hospital, however, does have many of the basic components of each of these, and other additional specific elements besides.

A hospital has waiting rooms, business offices, laundry, kitchens, etc. In addition, it has patients in various states of health and sickness and happiness and despair. Because the patient is the most important individual in the hospital, his general state of well being and health is the prime concern of the personnel who contribute to his care. Because the *human* element is so important in the hospital, tensions must be reduced if the patient is going to receive the full benefit from his hospitalization. Background music can help reduce these tensions and make life in the hospital more pleasant for everyone.

The patient is the most important individual in any institution, but in order that the patient may have a bed to lie in, food to eat and the ever-present care which he is entitled to expect, it is necessary that there be certain full-time personnel to supply these needs. It is just as important to keep hospital employees happy, in order to produce good results, as it is to

MUSIC AND ANALGESIA

The use of music in anesthesia is a relatively new venture which some day may become a truly useful tool in the hands of the anesthesiologist.

Today, physicians believe that just enough anesthesia should be given for the necessary surgery to be performed quickly, painlessly and with as little memory of the procedure as possible for the patient. By combining the use of music with the administration of minimal doses of sedative drugs and an anesthetic gas plus oxygen, profound sleep can be produced. When sleep occurs, muscle relaxing drugs may then be given after which surgery may begin. After a period of minutes on this combination of anesthetic agents, the gas may be discontinued and the patient may be given only oxygen while the background music continues. At the completion of the surgery, both the oxygen and the music are stopped and the patient awakens.

Music in anesthesia can be used for all age groups. Although the background music in the operating room has a calming effect on the patient while he is awake, headphones should be used for specific treatment of the patient. The regular program can be relayed to the patient via the headphones, but it is usually more practical to use a separate reproduction instrument. If a microphone and a cut-in switch are used, the anesthesiologist can talk directly to the patient while he is going to sleep. This is called vocal anesthesia.

When music is properly used as an adjunct to other recognized anesthetic agents, even the poor-risk patient can receive necessary surgery with a reduction in the calculated risk of various time-tested anesthetic procedures. Of course, it is not anticipated that anyone will ever be operated on while under the influence of music alone. As in other fields of investigation, however, progress in research concerning the use of music in anesthesia is just beginning.—R.H.B.

'MELODIES FOR MALADIES'

"Piped" music at the Mary Hitchcock Memorial Hospital has been made possible by funds donated to the hospital especially for this purpose. The project has been called "Melodies for Maladies".

When a new addition was constructed in 1952, wires for music were put into the partitions leading from the central anesthesia workroom to each of the eight operating rooms, the anesthesia room itself and the postanesthesia room. Sufficient funds were not available to install a high fidelity reproduction system to these areas, however, for five years. Now the system is in operation and even the large main business office has been "piped" for music from the control center in the anesthesia workroom. The business office staff itself paid for half of this additional installation.

At Mary Hitchcock Memorial Hospital, the central supply of specially recorded background music consists of 200 selections. Each month, 25 of these recordings are changed in order to avoid monotony.

keep machine shop workers or personnel in large business offices happy, for the same purpose.

At the Mary Hitchcock Memorial Hospital, Hanover, N.H., "piped" music has been in use for soothing patients and personnel alike for approximately five years. In such a program, no attempt is made to change the music tastes of patients or personnel, but to pipe in a type of music that is not irritating and contains no rasping or clanging or no extremes in high or low tones. No vocal or tympany accompaniments are used. Music with a preponderence of strings or woodwinds, which can be reproduced faithfully on high fidelity equipment, is used predominately in the piped music program.

This type of music is to be heard —not listened to. There should be only a subconscious realization of its existence so that the busy individual is not distracted by it. The realization of the presence of background music should be evident only when the absence of it gives one a feeling that "something is missing".

In any given institution in which music is being reproduced at the "background" level, the same music, at the same amplification, must be heard in all departments or areas in which the reproduction equipment is in use. In a hospital, for example, music heard in the waiting rooms must be the same as that heard in the corridors, in the business offices, in the dining rooms and the laundry. If this does not occur, any individual passing from one area to another within the building becomes distracted immediately by the change of themes or amplification. Such distractions result in nothing short of irritation to employees and patients alike, defeating the entire purpose of the program.

For the program to be effective, only the best reproduction system should be used—second best could defeat the whole purpose of the program. There are many good high-fidelity reproducing systems on the market today. The type which any institution should install is a matter of choice, often influenced by finance or fancy.

A reputable electronics engineer who has knowledge of music reproduction should be consulted for the basic survey of equipment, supervision of installation and especially for maintenance. If it is poorly maintained, expensive high-fidelity equipment may give completely unsatisfactory reproduction, while cheaper equipment may produce the ultimate in fidelity if maintenance service is good. Electronic high-fidelity music systems are only as good as the know-how to keep them in perfect operating condition.

PROGRAMING

Although background music in institutions is not "listening music", it would be ridiculous to play the same selections over and over again. The monotony of this situation would create great unrest. Programing is a very important feature in background music. A carelessly programed music system would be worse than none at all. This is important in selection as well as timing. There should be periods of play as well as rest. Whether these invervals are in the ratio of four-to-one—that is, one hour on and 15 minutes off—or some other ratio, such as six minutes on and eight minutes off, will depend on the institution concerned. It is believed that six minutes on and eight minutes off is probably the most practical program arrangement for most hospitals. However, this is not a fixed ratio.

Selections for the programing must be specially recorded with the actual purpose of their use always kept in mind. It is possible to go into a music store and choose several recordings or magnetic tapes which would be suitable for background reproduction. But to find even a few suitable selections, it would be necessary to listen to hundreds. Many of the nearly suitable selections can be eliminated because of a few high notes, changes in tempo or some other feature, which, under ordinary circumstances, would not be noticed by the listener.

Assuming that proper recordings are available, programing must be controlled by one or two individuals. Music system programing is not proper work for a committee.

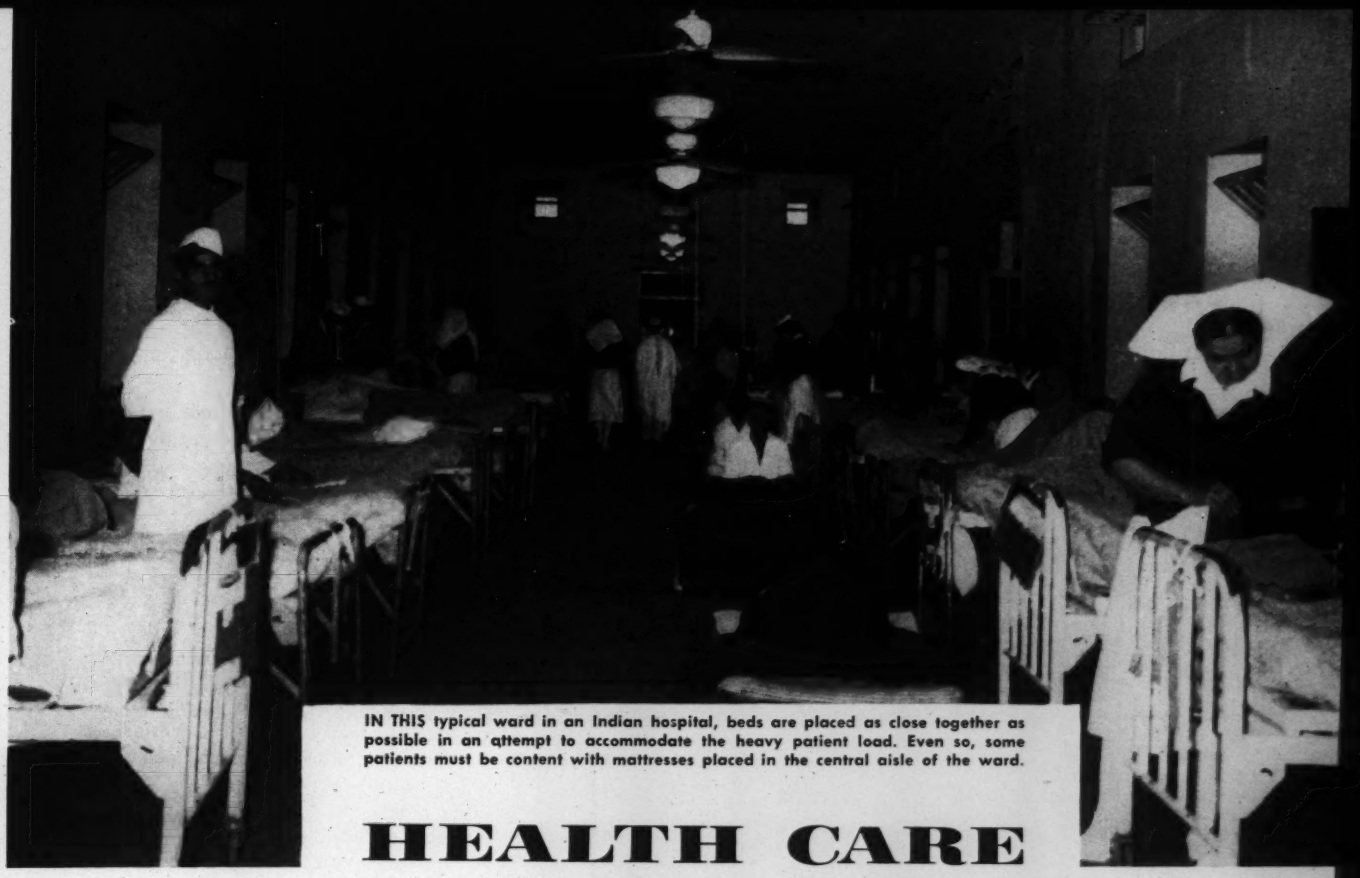
The average teen-ager should not be in charge of programing hospital or any other institutional background music; neither should the average professor of music hold this position, *unless* he is well aware of the purpose and the desired results.

SELECTIONS

Background music should be anything but morbid. The patient going to surgery should be in a happy mood and in pleasing surroundings—not in the usual ultra-silence, marred only by the clanging of a few instruments. Many funeral homes now make use of semiclassical or classical recorded music, but these types of recordings should be avoided for general use in hospitals. This may be a fine point, but it is certainly one of the finer points to be regarded.

Seasonal music, such as Christmas carols, should be avoided except in nonpatient waiting areas, and the playing of this music should not start too early in the season concerned. Generally, hymns should not be played because of their effect on many patients and their families and friends.

Hospital background music is not planned for the classical music lover or the serious student of music. In planning such a program, not only must the various selections and sound reproduction systems be chosen with care, but the temperament, education, religious training and general emotional environment of the patients and personnel must also be considered if the program is to be successful. Anything less than careful planning in these areas could result in something worse than a failure. Everyone hearing the background music cannot be pleased at all times, but it is important that as few people as possible be irritated by the selections or the quality of the sound reproduction system. This is a difficult prescription to fill, but it can be done with carefully measured ingredients. ■



IN THIS typical ward in an Indian hospital, beds are placed as close together as possible in an attempt to accommodate the heavy patient load. Even so, some patients must be content with mattresses placed in the central aisle of the ward.

HEALTH CARE IN INDIA:

ITS PATTERNS AND PROBLEMS

Conclusion of a two-part article by JOHN R. McGIBONY, M.D.

In the concluding part of a two-part article on Indian health problems and resources, the author discusses teaching facilities for medical and paramedical personnel, giving the ratios of these individuals to population. He also discusses Indian hospital facilities, including number of beds, outpatient department demands, patient costs and plans for future development.

In Part 1, appearing in the May 16 issue of the Journal, the historical, cultural, economic and political forces influencing the health status of India were discussed.

THE NUMBER of medical colleges has increased from 30 in 1951 to 58 in 1960, and several more are in the planning and construction stage. All but two, which are church owned and operated, are operated by the government.

Applicants to the colleges are selected by examination from groups numbering 15 or 20 times as many as can be enrolled. Selection is made on a purely mathe-

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Table 2—Medical college affiliated teaching hospitals, 1959.

State	Teaching Hospitals	Number Beds
Andhra Pradesh	14	6,032
Assam	1	511
Bihar	2	1,732
Delhi	8	3,627
Gujerat	8	1,913
Kerala	2	770
Madhya Pradesh	8	2,825
Madras	13	7,795
Maharastra	16	4,154
Mysore	10	3,407
Orissa	1	593
Pondicherry	1	570
Punjab	9	2,425
Rajasthan	2	818
Uttar Pradesh	7	2,448
West Bengal	12	5,505
Totals	114	45,125

matical rating of grades, without reference to other factors pertaining to potential as physicians. The student who is accepted must be a high school graduate and have had at least two years of college premedical work, largely in the natural sciences. Approximately one-fourth of the students at the present time are women.

The first two years are given to the preclinical subjects. The third, fourth and half of the fifth years are largely clinical experiences in the wards and outpatient departments.

The student takes a series of comprehensive examinations, given through the university, not the college, and if he is successful, he receives the M.B.B.S. degree and is permitted to practice medicine. Should he wish to specialize, he continues as a resident, after which he may take the examination for one of the various specialty degrees.

Clinical material available for teaching purposes is limitless. In fact, there is so much that it tends to lose its effectiveness because of patient loads in the over crowded hospital wards and congested outpatient departments.

Approximately 3000 students now graduate annually, while India needs 3200 each year to maintain its present physician-population ratio.

There are 114 medical college-affiliated teaching hospitals with 45,125 beds, almost one-fourth of all hospital beds in India (Table 2, page 48).

In addition to the specialists and M.B.B.S. graduates, around one-half of the present practicing physicians are licentiates, a group who for many years were trained through minimum programs operated theoretically to provide some level of medical care to rural areas. The number is being reduced fairly rapidly.

There is still a large but unknown number of native practitioners of Ayurvedic (knowledge of life) medicine. This system apparently made many contributions to the fields of anatomy, physiology, surgery and therapy until its period of stagnation set in approximately 2000 years ago. Since that time, it is reputed to have evolved largely into an inherent native superstition and mysticism.

No discusssion of Indian medicine is complete without mention of many contributions made to progress in the medical sciences. The name of Susruta stands out as one who, historically, compiled a remarkable description and classification in the fields of surgery, medicine, pathology, anatomy, midwifery, biology, ophthalmology, hygiene and psychology. Some historians have placed him as early as 400 B.C.

Fig. 1—Indian physicians according to occupation.

	Hospital Service	Public Health	Tecching
Specialists	46%	10%	41%
Graduates	61	3	20
Licentiates	91	5	—

PHYSICIANS

In 1956, the latest year for which figures are available, there were 71,600 physicians in India, giving a ratio of 176 to each million of the population, as compared to 119 in Burma, 286 in Egypt, 417 in Mexico, 1000 in Japan, 1316 in the United States and 1667 per million in Russia.

Of Indian physicians, 4100 (5

Fig. 2—Physician distribution in India.

State or Territory	Physicians per million population (1956)
Jammu & Kashmir	16
Manipur	40
Rajasthan	40
Himachal Pradesh	64
Madhya Pradesh	72
Orissa	84
Uttar Pradesh	95
Kerala	116
Andhra Pradesh	120
Bihar	126
Mysore	143
All India Average	176
Punjab	182
Madras	193
Bombay*	253
Tripura	255
Assam	280
West Bengal	605
Delhi	642

*The state of Bombay was recently divided into the States of Gujerat and Maharastra. Separate figures are not available at this time.

per cent) are classified as specialists (board certified), 29,100 (41 per cent) as graduates, and 38,400 (54 per cent) as licentiates. These groups are occupied in various capacities (see fig. 1, p. 48).

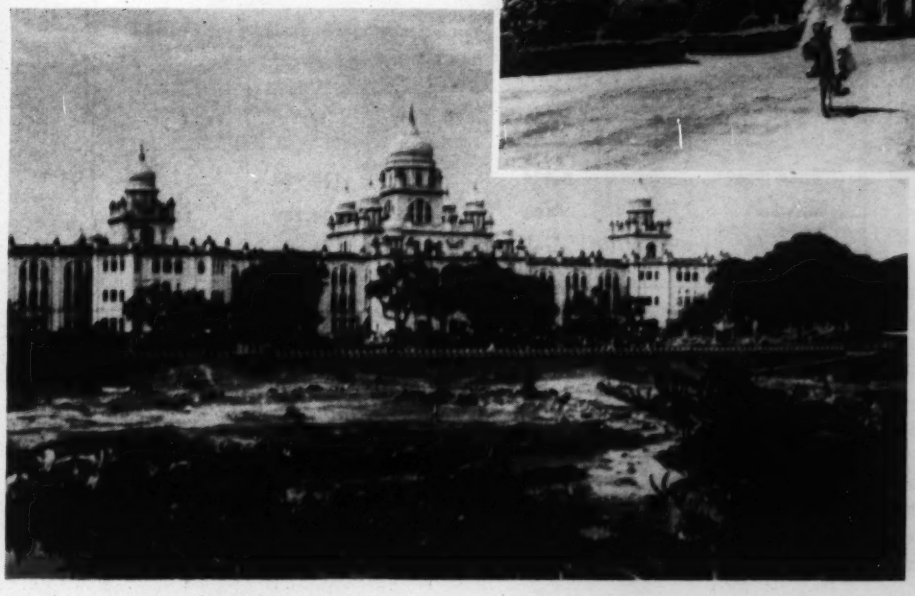
Only 11 per cent of all physicians reside in rural areas, where at least 80 per cent of the people live. Thus, the average ratio of physicians per million population leaves much to be desired for medical care of rural groups, which may have as many as 50,000 people for each physician. Four out of five of the physicians in the rural areas are licentiates. (See fig. 2, left)

Of all physicians, 7.5 per cent are women. More than 60 per cent of these are graduates, but less than 1 per cent of the women physicians are in rural areas.

DENTISTS

One is impressed with the fact that a major portion of the larger hospitals in India have incorporated at least some dental services into their activities. At the same time such services, like those for the general public, are necessarily severely limited, largely because of the lack of qualified dentists.

Before 1948 there were few, if any, standards and regulations for the practice of dentistry. Any individual so inclined could set himself up as a dentist, determining his own qualifications. There is



TWO OF the larger hospitals in India are shown in these photos. The Osmania General Hospital (left), Hyderabad, Andhra Pradesh State, is an 850-bed institution; the Ghandi Memorial Hospital (above), Lucknow, Uttar Pradesh State, has 888 beds.

still a fairly large number of such practitioners (4000 to 5000) but they are rapidly disappearing following the Dental Practices Act of 1948. Future licensing is limited to dental college graduates, of which there are now approximately 1200.

There are now 10 dental colleges in India, with plans calling for more in the near future. Each admits approximately 25 students for each class for the four-year course.

NURSES

Most of the larger hospitals operate schools of nursing. As of October 1959, replies to questionnaires of the Indian Nursing Council showed that there were 359 schools of nursing (plus eight known, but not replying). Of these, 171 were governmental, 180 private and 8 municipal. Students in training in 1958 were in the following categories:

general nursing	9807
bachelor of science candidates	156
auxiliary nurse-midwife	3675
midwifery	2636
health visitors	1106

Some difficulty is experienced in many areas in obtaining students of high quality, because of lack of interest in the profession on the part of girls.

A major portion of nursing care in hospitals is supplied by students. There is considerable emphasis on midwifery; all nurses are required to do a certain number of deliveries, and in many hospitals all normal deliveries are done by "sisters" (supervisors).

The student nurse usually receives food, room, uniform allowance and approximately $5 per month. The beginning salary of a staff nurse, including allowances, is $35 to $40 per month.

The total number of registered nurses in India as of December 1958 was 28,049, or one to every 13,000 of the population. This compared to approximately one to every 400 population in the United States. The ratio of nurses to physicians is also reversed in the two countries, with India having about one nurse to each three physicians.

The directorate general of health services recently published the first directory of hospitals, covering the year 1957. Because some hospitals failed to return the questionnaire, the figures in Tables 3, 4, and 5, above and right, while still lacking something in completeness, are the result of hand tabulation of directory data. Additional and later information, as well as estimates and

Table 3—India hospitals*, reports and estimates, 1960.

State	Number Hospitals	Number Beds	Population	Beds Per 1000
Andhra Pradesh	186	19,189	37,000,000	0.52
Assam	25	3,560	9,000,000	0.39
Bihar	83	8,248	45,000,000	0.18
Delhi	39	5,937	2,500,000	2.37
Gujerat	66	5,507	19,138,000	0.28
Himachal Pradesh	22	1,160	1,600,000	0.72
Jammu-Kashmir**	5	279	5,000,000	—
Kerala	122	11,641	16,800,000	0.61
Madhya Pradesh	189	14,551	30,000,000	0.48
Madras	190	21,593	35,500,000	0.61
Maharastra	182	22,540	37,652,000	0.60
Manipur	9	345	750,000	0.46
Mysore	120	10,973	24,100,000	0.45
Orissa	105	4,992	16,800,000	0.30
Pondicherry	4	838	435,000	1.92
Punjab	131	8,744	18,300,000	0.48
Rajasthan	141	8,387	18,200,000	0.46
Tripura**	2	40	700,000	—
Uttar Pradesh	279	17,199	72,500,000	0.23
West Bengal	218	21,654	30,500,000	0.71
Andam. Nic. Islands	1	388	50,000	7.70
Totals	2,119	187,765	421,525,000	0.44

*Excludes institutions with less than 12 beds.
**Limited reports available.

Table 4—Indian hospitals by ownership.

By Ownership	Hospitals*	Per Cent	Beds	Per Cent
Government	1,544	73	135,993	73
Mission	403	19	34,289	18
Other	172	8	17,483	9
Totals	2,119	100	187,765	100

*Excludes institutions with less than 12 beds.

(LEFT) Occupancy rates in Indian hospitals are so high that frequently no beds are available for emergency cases. In this scene in a children's orthopedic ward, a mother comforts her child as a nurse prepares to administer a transfusion.

interpretation on the part of the author, have been included but are not official. Estimates have been made that there are actually at least 5 to 10 per cent more hospitals and beds than the figures show. Institutions with less than 12 beds have been arbitrarily excluded, since few of them could be really classified as hospitals. The average size for all hospitals is 88 beds.

Estimates of utilization of hospital resources indicate that approximately 15,000 patients are admitted daily for a yearly total of approximately 5.5 million; this makes for an annual admission rate of around 13 per thousand population. With an average stay of 10 days, the total hospital days per year would be 55 million. Occupancy rates run more than 100 per cent in a vast majority of hospitals, necessitating use of areas not designed for patients' beds. Also, wards designed for 10 to 50 beds must be uncomfortably crowded.

Outpatient departments are so overwhelmed with those seeking ambulatory care that the staff finds it extremely difficult, if not impossible at times, to give the quality of care desired. The average hospital has approximately 500 outpatients annually for each hospital bed.

Table 5—Indian hospitals by size.

Number of Beds	Total Hospitals	Per Cent	Total Beds	Per Cent
12 -24	684	32	9,586	6.5
25 -49	516	24	20,104	10.6
50 -99	404	19	27,525	14.5
100-149	198	9	25,643	13.5
150-199	86	4	14,973	7.5
200-299	96	4.5	23,908	12.6
300-499	75	3.5	22,969	12.1
More than 500	60	3	43,057	22.6
Totals	2,119	100	187,765	100

AVERAGE PATIENT COST

Average daily cost per patient is estimated at around 8 rupees ($1.68), which includes costs of salaried physicians. Roughly one-sixth of this amount is for outpatients and a similar amount for dietary services.

Quantitatively, it will be noted in Table 6, page 52, that India, with its 0.44 beds of all types per thousand population, is a far cry from the 10 or more beds per thousand found in some Western countries. Such latter numbers would

Table 6—Hospital use, facilities and costs projected through 1976.

(1960 figures are estimates)	1960	1961	1966	1971	1976
1. Total population	420,000,000	425,000,000	470,000,000	530,000,000	600,000,000
2. Total ill daily (2 per cent of total population)	8,400,000	8,500,000	9,400,000	10,600,000	12,000,000
a. Given outpatient care	256,000	280,000	335,000	480,000	821,000
b. Need hospital admission					
(a) Number	21,000	25,500	37,600	53,000	60,000
(b) Per cent of total ill	0.25	0.30	0.40	0.50	0.50
c. Admitted to hospital					
(a) Number	15,000	16,500	24,000	37,000	60,000
(b) Per cent of total who need admission	71.0	64.0	64.0	70.0	100.0
3. Annual admissions to hospital					
a. Total	5,500,000	6,000,000	8,700,000	13,500,000	22,000,000
b. Rate per thousand population	13	14	18	25	36
4. Hospital beds available					
a. Total	187,765	203,000	245,000	350,000	600,000
b. Per thousand population	0.44	0.47	0.52	0.66	1.0
5. Operating costs					
a. Total annual cost	$88,000,000 (44 crores*)	$96,000,000 (48 crores)	$156,000,000 (78 crores)	$270,000,000 (135 crores)	$528,000,000 (264 crores)
b. Cost per patient day	$1.68 (8 rupees**)	$1.68 (8 rupees)	$1.89 (9 rupees)	$2.10 (10 rupees)	$2.52 (12 rupees)
6. Annual hospital construction cost (based on $4000 per bed)	$60,000,000 (30 crores)	$168,000,000 (84 crores)	$420,000,000 (210 crores)	$1,000,000,000 (500 crores)	— — —

*Crore = $2,000,000
**Rupee = 21 cents

not be indicated for India at the present time even if economic barriers were not of such major proportions. A much greater need is for fewer patients, but such a goal can be reached only through strong, dynamic programs in prevention, health education and sound, efficient, outpatient ambulatory services. Such programs are being pursued with vigor by the authorities. The Third Five Year Plan, which began in April 1961, will probably place great emphasis on placement of primary health centers in the villages.

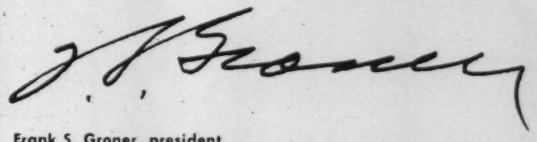
It is hoped that resources will permit equal emphasis on increasing, enlarging and strengthening the hospitals, particularly those having the responsibility for medical care of the masses and for education in the medical and allied professions.

It would appear that a logical goal through the Third Five Year Plan (1961-1966) and through the fourth and fifth of these plans, extending to 1976, would be 1.0 bed per thousand population (see Table 6, above).

Such proposed expenditure may appear staggering initially in India's present economy. On second thought, the question becomes not whether India can afford it, but if it can afford not to expend these rupees each year for more and better hospitals.

A basic element of the underlying social philosophy of India is that the health of the nation is a natural resource. It is one of the universal human values and directly proportionate to the progressive intellectual, moral and physical vigor of the people upon whom national progress depends. The better the hospital and the physician and health worker, the better the health of India. ■

YOUR PRESIDENT REPORTS



Frank S. Groner, president
American Hospital Association

A 'Code of Conduct' for hospitals and a stronger Blue Cross approval program

THE REORGANIZATION of Blue Cross nationally, completed in October of 1960, is but the beginning of a strong Blue Cross-hospital relationship. Before this partnership becomes a vital reality much needs to be done by the Blue Cross Association and Plans and by the American Hospital Association and hospitals.

Strengthening the Blue Cross Approval Program and developing a "Code of Conduct" for hospitals are of major consequence to the success of the partnership. Both of these have been undertaken by the American Hospital Association.

Revised principles and standards for approval of Blue Cross Plans are currently being tested for effectiveness prior to their submission to the AHA Board of Trustees. We believe that in their final form they will provide greater opportunities for analysis and evaluation than the present standards. It is the intent of the AHA and the BCA that the Approval Program raise Plan operations to the same high level that medical staff procedures in hospitals have been raised by the accreditation program.

Although accreditation has expanded to cover some aspects of hospital management, it is essentially medical staff oriented. For purposes of the partnership, it does not say enough about management and it says nothing at all about how it relates to Blue Cross.

This lack of standards for the nonclinical side of hospitals has become an increasing problem as the number of patients covered by Blue Cross has grown. More and more instances are found in which individual hospitals acting independently are causing a strain on the hospital-Blue Cross relationship and are jeopardizing Blue Cross' ability to render its services. Consequently, the American Hospital Association has undertaken the development of a set of performance standards—a code for hospitals—to assist hospitals in fulfilling their obligations to Blue Cross and to the community.

THE PROPOSED standards, as they now stand, are more broadly based than those of accreditation, covering aspects of hospital administration with special emphasis on the hospital's responsibility to Blue Cross. They are being tested in more than 150 hospitals across the country to ascertain their universality and effectiveness.

These principles are not final. Before they become the policy of the American Hospital Association they will have been thoroughly tested, studied and, perhaps, revised, to assure their applicability in all instances.

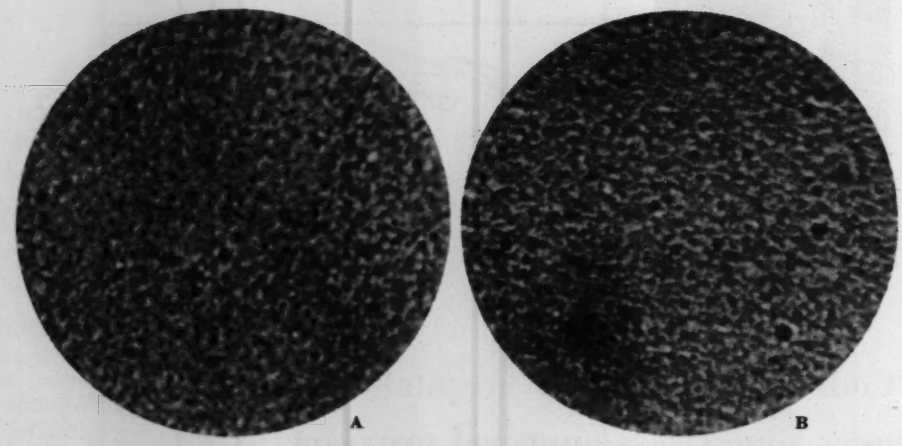
To test the standards we have asked each of the ten members of the Council on Blue Cross, Financing and Prepayment, and the seven members of its Committee on Standards and Evaluation, in cooperation with their state or local hospital association, to select as test sites 10 hospitals which are broadly representative of various sizes, services and types of ownership. They have already begun to test the standards to determine clarity of the questions and to evaluate the criteria.

When the hospitals have completed the questionnaire, each group of 10 will meet. At this meeting they will analyze the results of their survey and write a report of their opinion on the program.

The report of these 17 meetings will be examined by our Council and Committee, and the suggestions will be incorporated into the final version of the performance standards.

We believe that the "performance standards" for hospitals will secure general acceptance, for it will reflect the best elements of the voluntary hospital and prepayment system. It will also demonstrate beyond a doubt that hospitals accept their share of responsibility in the hospital-Blue Cross partnership. More than this, in voluntarily adhering to the performance standards, hospitals across the country will take their rightful place of leadership in the promotion of continuously improving patient care.

In the final analysis, improved Blue Cross approval standards, together with the "Code" will provide the framework in which a true partnership can be forged. This is a partnership which is equipped to serve the public's health needs at the highest possible level of economy and efficiency.



A B

Which is chyle and which is Lipomul I.V.?†

As you know, after digestion, fat passes as an emulsion called chyle through the lacteals into the lymphatics tributary to the thoracic duct, and then into the systemic circulation. Lipomul I. V., like chyle, is a fine milk-white emulsion of fat. Its fat particles approximate those of chyle in size: about *1/7 the diameter of the normal red blood cell.* Because of this minute particle size, like chyle, Lipomul I. V. is *non-irritating to the vein.* The fat provides *8 times more calories* per cc. than does 5% glucose and with markedly increased protein-sparing action. It is *swiftly* and *completely metabolized.* Therefore, when formation of chyle, a major source of calories, is blocked during pre- and post-operative "digestive tract bypass," many surgeons add Lipomul I. V. to their standard fluid and electrolyte regimen to provide the most concentrated source of energy.

†**A**—Mammalian chyle (highly magnified)
B—Lipomul I. V. (highly magnified)

Formula:

Cottonseed oil	15% w/v
Dextrose anhydrous	4% w/v
Lecithin	1.2% w/v
Oxyethylene oxypropylene polymer	0.3% w/v
Water for injection	q.s.

Supplied in 250 cc. and 500 cc. bottles

Indications and effects

Lipomul I. V., fat emulsion for parenteral use, supplies approximately 400 calories per 250 cc. It is indicated in patients who are unable to take adequate food by mouth for any considerable period of time.

Administration and dosage

Administer only by intravenous route, as follows:

For adults	
First 5 minutes	10 drops/minute
Next 25 minutes	40 drops/minute
Then	60 drops/minute
For infants and children	
First 5 minutes	5 to 10 drops‡/minute
Next 25 minutes	0.5 to 1 drop per pound/minute
Then	0.5 to 1 drop per pound/minute

‡*1 cc.—approximately 20 drops.*

Precautions and side effects

To administer, use only the recipient set supplied in the package; Lipomul I. V. must not be mixed with transfusions, infusions, or any other parenteral medication, or be given simultaneously through the same tubing. A total of not more than 14 units (500 cc. each), at a rate not exceeding 2 units per day, should be given to any one patient.

Reactions of a "colloid" type may occur, including back or chest pain, dyspnea, severe flushing, or urticaria. There may be delayed chill. Transient fever has also been noted, as have such other minor reactions as nausea, vomiting, abdominal discomfort, headache, mild flushing, dizziness, and some variations in blood pressure and pulse.

When the recommended dosage is exceeded, an "overloading syndrome" may occur characterized by chill, fever, abdominal pain, nausea, vomiting, hepatomegaly, clotting defects, thrombocytopenia, and bleeding, particularly from the gastrointestinal tract.

Lipomul I.V.
Trademark, Reg. U. S. Pat. Off.
THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

Upjohn
75th year

AN IMPORTANT aim of the constant care program for "T & A" patients at Long Island Jewish Hospital is to allay the anxieties of the parents. Here a volunteer answers a question regarding hospital procedures.

A constant care program for 'T & A' patients

(Continued from page 39)

care. This is the hospital's responsibility. Without doubt, the children's well being and the parents' peace of mind would be enhanced if provision were made for constant experienced nursing care during their stay. Thus, what was tantamount to an "intensive care unit" for T & A patients emerged as the salient and distinctive feature in our program.

INCREASED COSTS A FACTOR

However, the problem of increased costs had first to be met. How could we offer such round-the-clock nursing service without an accompanying upsurge in expenditures? The answer lay in the principle of "economy in numbers", our scheduling of a specific number of operations (usually eight) on specially designated days, such as Tuesdays and Thursdays. Such an organized schedule permits maximum use of both the operating room and anesthesiology services at a particular time.

Then, too, the grouping of the "T & A" patients in a room separate from the regular pediatric patients not only makes it possible for one nurse to care for the eight youngsters without difficulty, but also reduces the likelihood of cross infection. From an administrative point of view, such an arrangement works out well. The efficiency of the pediatric unit is not impaired in any way, since the general staff has little responsibility for the care of these patients.

Two nurses are assigned to the "T & A" room: one for the 4 p.m. to midnight shift; the second for the midnight to 8 a.m. shift. Earlier in the day, nursing care is provided by a specially trained corps of volunteer workers under the direction of the pediatric supervisor, who assumes this "T & A" assignment on a regular weekly basis. As most of these volunteers have been with the program from its very inception, they bring to it the knowledge and perception that both experience and understanding nurture.

BUILDING SECURITY

Aside from continuous nursing care, what else can administration do to ensure a feeling of security? Surely if parents are enlightened as to every procedure and every step along the way, they will be less apprehensive. Thus parents are given a full explanation of the day's happenings in a two-page letter which was prepared by the administration in conjunction with the chief of staff in pediatrics, the director of nursing services, the pediatric supervisor and the attending staff of ear, nose and throat specialty.

Incidentally, throughout the development of this program, pe-

riodic evaluations have brought about a close liaison among these groups. This cooperation, coupled with the participation of the volunteers, has created a successful team effort.

After the parents read the letter, they, in turn, tell their children what to expect during the hospital stay. This kind of orientation, we have found, lessens the trauma of the hospital experience for both parent and child.

In the letter, parents are first asked not to give their child breakfast except for a carbonated beverage, water, strained orange juice, or tea. They are asked to bring a urine specimen with them.

Next, in chronological sequence, the day's schedule is outlined together with instructions for checking out. The letter ends with the assurance that "the health and comfort of your child will be our constant concern during his stay here."

LETTER CALMS PARENTS

Apparently our letter does contribute to the parents' peace of mind. "We appreciate your full report on procedure," said one mother. "Knowing what was going to be done somehow made us more relaxed. It seems that Nancy sensed our calm and reacted much more favorably than we had expected. Perhaps the fact that she was not alone, that she was sharing this experience with other children, made her rise to the occasion. Then, too, that extra bit of reassurance given by your dedicated volunteers made us feel instinctively that she was in 'good hands'. Thank you for making Nancy's first hospital experience a relatively pleasant one in spite of her discomfort."

The role of the volunteers, nurses and other personnel can best be illustrated by a review of what happens on every Tuesday and Thursday at the Long Island Jewish Hospital.

The eight youngsters with their parents arrive in the hospital lobby approximately at 9 a.m. A volunteer greets them and escorts two children at a time to the examining rooms in the emergency suite. There the volunteer and physician work as a team utilizing two examining rooms. After a child is undressed, his weight, temperature and morning food intake are checked by a volunteer. The pediatric resident then examines throat, ears and chest. He inquires about any recent illness at home and checks for bruises and scars. If there is no untoward sign such as elevated temperature or a rash, the patient is dressed and proceeds to the admitting office.

PLAYROOM NEXT STOP

After the first four patients have been formally admitted and given their identification bands, one of the volunteers escorts them to the pediatric floor where, under her direction, they enjoy a "get-acquainted" period in the playroom. When the other "T & A" patients, led by the second volunteer, join them, the entire group is greeted by the pediatric supervisor who takes them to the large bright "T & A" room complete with eight cribs, bedside tables and clothes closets. The cribs have been name-tabbed earlier, and each child runs to claim his own. (Since the cribs are large, children as tall as five feet can sleep comfortably in them. Each patient is transported to the operating room in his own crib and returned to it immediately after surgery.)

Soon after the youngsters are undressed, a laboratory technician appears and quickly goes from one child to the next taking blood samples. The anesthesiologist follows him, seeing each child in turn and writing his "pre-op" medication orders on the charts. One of the volunteers produces books, crayons, games and toys. For a change of pace, the television set is turned on.

While this activity is going on, the other volunteer assembles the parents in a group, reviews the day's procedure, answers questions and informs them they will have to leave in a few minutes just before the first medication is given. She also suggests that they pay their bill at this time to prevent any unnecessary delay the next morning when they call for their children.

There is a subdued noise about the room as the parents say their good-byes. Even those yearning to linger a few moments longer go along with the group. Soon after they leave, at about 11:30 a.m., the nurse on floor duty checks each child, and proceeds to give the first child scheduled for surgery his preoperative medication. Thereafter, she appears at intervals of 20 minutes to give every other child his medication following the sequence of the operating room schedule.

The operating room attendant appears at the nurses' desk with a slip listing the name of a particular child and his physician. A nurse accompanies the orderly to the crib to check the patient's identification band. Then the sleeping child is taken to the operating room. The same procedure is repeated until all children have been wheeled out with the volunteer remaining in the room the entire time.

ROOM PREPARED FOR RETURN

While the youngsters are in the recovery room with the recovery room nurse carefully checking each patient, up on the floor the room is being readied for their return. The pediatric supervisor checks to see that sets of fresh linen, including towels and gowns, as well as basins, tissues, paper cups, tongue blades and thermometers, are all laid out. The suction machine is checked and double-checked.

Meanwhile, the parents wait in the lobby where the physicians see them immediately after the operation to give a full report on the procedure.

The children remain in the recovery room as a group until all can be safely moved. After the nurse and recovery room aide bring the first child back, the nurse stays with him while the aide returns with each of the other children in turn. About 7 p.m. there is a quiet excitement in the corridors as parents take their turn looking through the door's window at their children. However, they are not allowed to visit with them, nor are they visible to the children. Soon after the resident and nurse check each child, necessary medi-

in local anesthesia

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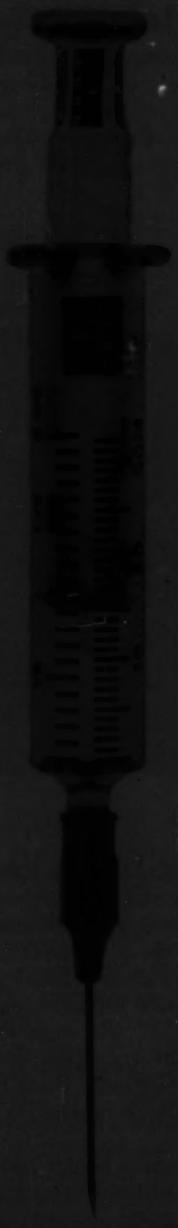
"...a noteworthy forward step...."[1]



Quicker anesthesia[2] / longer lasting anesthesia[3] / no epinephrine needed*[4] / virtually no vasodilatation[4] / greater safety[5]. "This combination of properties offers the opportunity of obtaining almost instantaneously profound and long-lasting anesthesia, with negligible tissue irritation, and without complicating systemic effects of vasoconstrictors."[1]

References: 1. Sadove, M. S., and Wessinger, O. D.: J. Internat. Coll. Surgeons 34:573, Nov., 1960. 2. Erickson, J. C., III, and Hricko, M. J.: Guthrie Clin. Bull. 29:45, 1959. 3. Gordon, R. A., Kerr, J. H., and Taylor, Russell: Canad. Anaesth. Soc. J. 7:290, July, 1960. 4. Sadove, M. S.: New Physician 9:39, Sept., 1960. 5. Young, J. A.: Anesth. & Analg. 39:451, Sept.-Oct., 1960.

*If desired, epinephrine may be used in infiltration anesthesia for hemostasis.

Winthrop LABORATORIES

cation is given and the youngsters are settled for the night.

The nurse, however, remains on guard alert to any possible emergency. In the event of hemorrhage, the specially assigned nurse calls the surgical resident and the floor nurse returns the child to the operating room. The "T & A" nurse does not leave her post. If she must go out briefly, a floor nurse takes over. The same holds true for her replacement on the midnight to 8 a.m. shift.

DISCHARGE PROCEDURES

Early the next morning before the physicians' discharge examinations, rectal temperatures are taken. Hands and faces are washed and nourishment in the form of gelatin dessert or cooled juices is offered. By 7:30 a.m., parents are already arriving, ready to leave with their youngsters. Before they do, the nurse gives them discharge instructions and prescriptions written by the physicians. An aide accompanies the children down to the lobby. After the children's departure the room is stripped, cleaned, washed, aired and made ready for its next group of occupants.

Through its doors pass more than 400 children each year. From the comments of both physicians and parents, we believe that our "T & A" program has given emotional comfort to these children during a trying time. Not only has the trauma of a strange new experience been lessened, but the groundwork for the individual's acceptance of medical care in the future has also been laid.

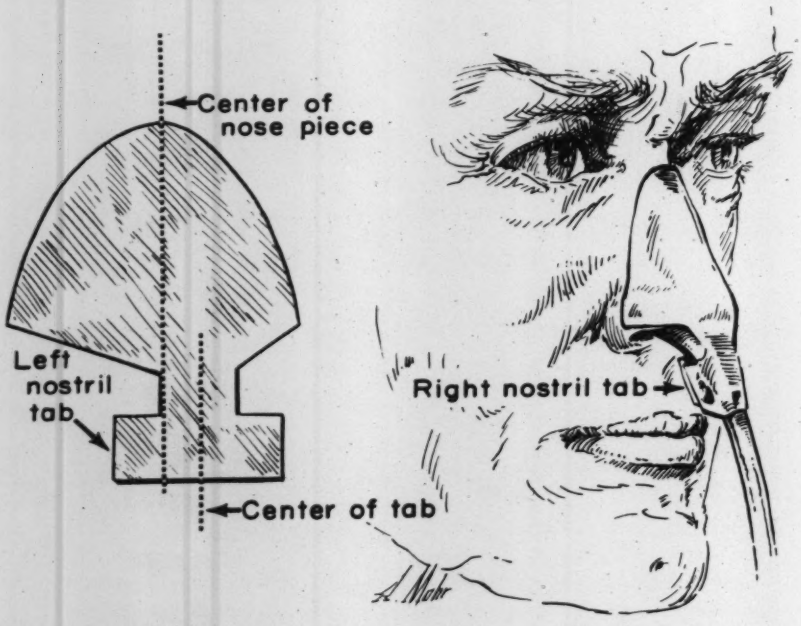
As emphasized earlier, we direct special effort toward ensuring the parents' peace of mind. When the mother and father believe that their child has received the best possible care, their gratitude extends to the physician as well as the hospital. Thus, anything the hospital does to reassure the parents strengthens the physician-hospital relationship.

It has been our experience at the Long Island Jewish Hospital that a carefully planned program with clear objectives extends beyond the hospital's walls and radiates its good influence in different areas. Ultimately it reaches the general community and helps to strengthen the hospital's image as the guardian of the people's health. ■

NOTES AND COMMENT

New method introduced for holding nasal tubes in position

A problem common to most patients subjected to nasal intubation for the purpose of either suction or long-time feeding is the difficulty involved in maintaining the tube in a fixed position. The usual method of fixation is the use of adhesive tape for adhering the tube to the nose, the cheek, or the forehead. This method is far from ideal, because adhesive



tape quickly loses its effectiveness, becoming stretched or loosened by perspiration, thereby allowing the tube to move in and out as the patient swallows. This motion and the obvious pressure against the alar rim of the nose creates an unpleasant irritation or cellulitis which eventually leads to ulceration if the condition is not corrected.

A new tube holder has been developed which is easily affixed to the nose, with no discomfort to the patient. It is constructed of a thin malleable aluminum, approximately .005 in. in thickness, and is easily molded to the nose by digital pressure; it may be bent in any direction whatsoever. The holder projects below the tip of the nose to secure the nasal tube clear of the nasal rim, thereby eliminating the rubbing and irritation produced by the old method of securing the tube (see figure). The thinness and type of material allows it to be cut, if necessary, by the ordinary bandage scissors. The holder, or splint, has on one surface a nontoxic, nonirritative adhesive which keeps it firmly in position and allows the projection below the tip of the nose to grasp the nasal tube securely. This splint is designed to fit the nose snugly and is as easy to apply as ordinary adhesive tape. Its outstanding feature is that it may be firmly secured without rubbing or irritation to the nose. These splints manufactured by Sterilon Corp., Buffalo, have been designed to fit both adults and children.—*Abstracted from an article by Edward J. Hill, M.D., in* J.A.M.A. ■

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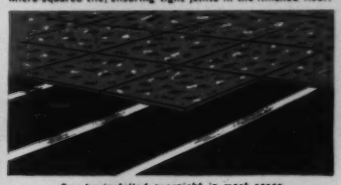

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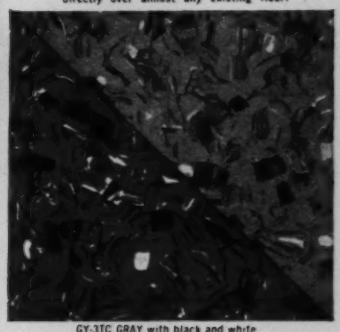

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GETTING THE MOST FROM BID BUYING

By EDWARD BLASZCZYK

Bid buying, formal or informal, can only be useful and valuable when the buyer and seller understand each other, the author states. A common meeting ground of descripitions and specifications of items considered is necessary before any intelligent action can be taken. Some pointers are given for using this purchasing tool to its fullest extent.

IN HIS daily efforts, the typical hospital purchasing agent employs various techniques. But his basic function is responsibility for the expenditure of funds in such a way that the hospital will reap the greatest return for the dollars expended.

Perhaps the purchasing agent's most commonly used tool is bid buying. The purchasing department of a hospital sends to suppliers a list of items. From the explanation accompanying the list, the purchasing department expects to receive prices. Then the purchasing agent assembles these bids and decides where and what to buy.

Why is bid buying so important?

A business firm realizes that when other firms are competing for an order, action must be taken to win the business. Prices may be cut as far as reasonable when a firm is presenting a bid. Inasmuch as the word "reasonable" can mean 10 different things to 10 different bidders, the hospital has an excellent opportunity to make a substantial saving.

Bids perform another valuable service to the buyer. They give the buyer the opportunity to use a subtle "squeeze" on a particular supplier. For example, a buyer is interested in a particular piece of equipment. Only one company distributes it. If the hospital purchasing agent asks the sales representative the price of the particular model, he will get in return only a quick reference to a price list and a quoted price.

When the bid system is used, however, there is no doubt in the buyer's mind that he wants the particular model above all others. Yet the buyer acts as if the model is one of several that interest him. He submits bids to other suppliers and lets the manufacturer of the model he really wants begin to worry. This manufacturer may be so concerned that he drops his price by a 5 or 10 per cent margin.

The ethics of the foregoing policy may seem a little immoral, but it should be pointed out that all firms are just as calculating. The purchasing officer can be manipulated by the suppliers just as easily. Only the most agile buyer emerges without scars.

Bid buying has a hidden feature; it protects the buyer's record of performance and honesty. Obviously, if a buyer can purchase identical or comparable merchandise at a lower price than he would have paid without a bid, he will certainly do it.

The purchasing agent finds that bid buying is a shield against attacks against his integrity. How often have purchasing agents been accused of having the best job in the hospital, especially at Christmas. Often he can laugh these off. However, when some serious accusation arises as to why he bought from this firm and not from that, he has only to disclose the bids submitted to justify his choice.

One final benefit, perhaps of lesser importance, is that bid buying keeps buyer-vendor relations on an impersonal level.

DISADVANTAGES OF BID BUYING

Bid buying, of course, is not a solution to all problems. The most destructive aspect of bid buying is that the buyer may grow to rely on price alone. Instead, he must constantly employ value analysis, as often the most expensive choice is the least expensive. With companies bidding against each other, they may tempt the purchasing agent into taking inferior merchandise. This problem can be controlled by rigid specifications; nevertheless, it is a pitfall in the bid buying system.

Hospital purchasing agents realize that they must have some established contacts that can be relied upon when certain conditions arise. By strict bid buying, the purchasing officer finds that dealers are reluctant to render that extra bit of special attention that he needs occasionally. Possibly some firm that does not have a local delivery point has been getting most of the

Edward Blaszczyk is purchasing agent, St. Mary of the Nazareth Hospital, Chicago.

arresting measure for surgical bleeding

When the customary surgical techniques for capillary hemostasis fail, prompt cessation of oozing may usually be obtained with OXYCEL (oxidized cellulose, Parke-Davis). This absorbable hemostatic conforms readily to all wound areas...assures a clear operating field...helps to shorten operative procedures.

Available in forms for every need: OXYCEL (oxidized cellulose, Parke-Davis). Pledgets (Cotton-type), 2¼ in. x 1 in. x 1 in.; Pads (Gauze-type) (8-ply), 3 in. x 3 in. and 4 in. x 12 in.; Strips (Gauze-type) (4-ply), 5 in. x ½ in., 18 in. x 2 in., 36 in. x ½ in., and 3 yd. x 2 in.; Foley cones (Gauze-type) (4-ply), 5 in. and 7 in. diameters. Sterile as supplied.

Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction. Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

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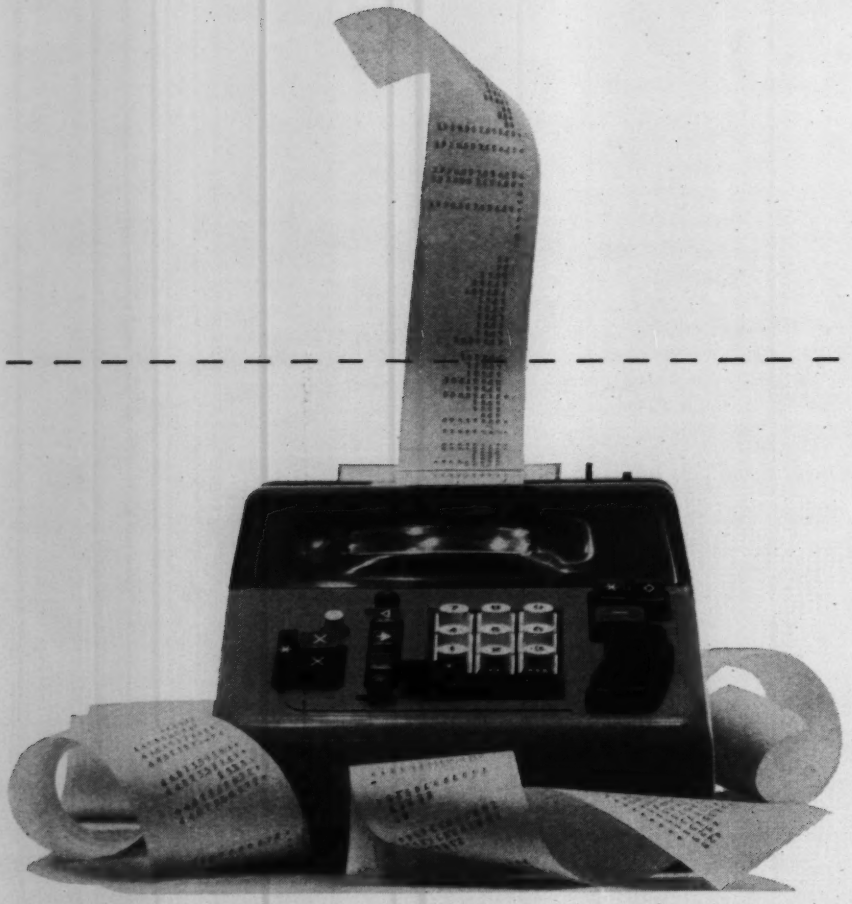
absorbable hemostatic

OXYCEL

Hospital costs rise and rise



The inflationary spiral steadily pushes hospital costs up—up—up. Hospitals help defeat the inflationary spiral by reducing costs of labor and equipment demanded by older, more time-consuming injection systems. By utilizing the TUBEX Closed Injection System, Wyeth, professional nurses are then used for nursing only and accounting is more efficient. Most important, costs can be billed accurately and justifiably to patients. As labor costs and equipment costs continue to rise, the economy of the truly modern injection system—TUBEX—inevitably will be realized by more and more hospital administrators.

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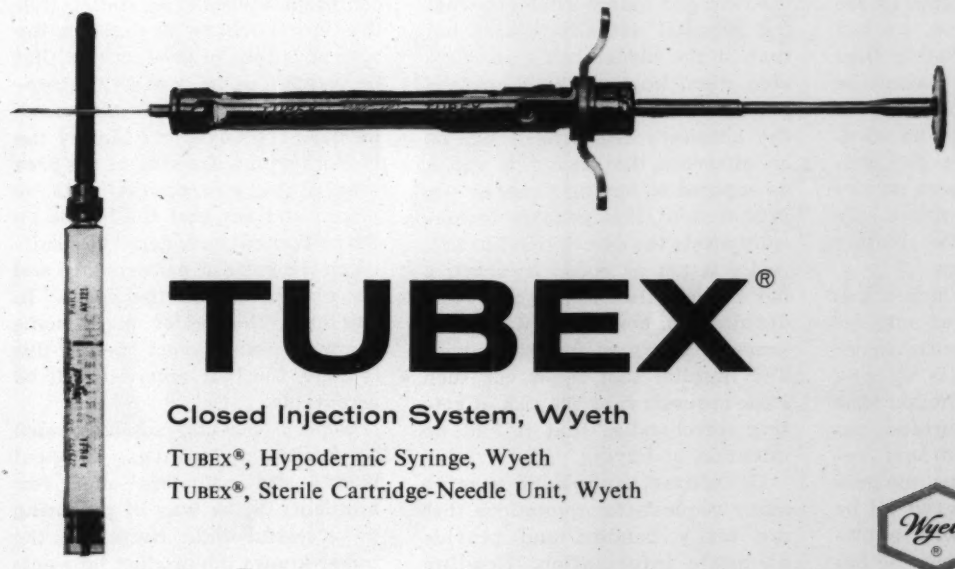

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orders because it has been "low man on the bid". Often times the differential amounts to one per cent or less than the quotation from a local supplier. For that smallest of all margins, the buyer has put himself in a poor position should an emergency arise. The purchasing agent should use common sense so that he can enjoy the benefits of bid buying and still have an "in" when the unforeseeable occurs.

A third argument against bid buying is perhaps that it can become too cumbersome and costly for the money it saves. Formal bid buying is time-consuming, particularly if specifications are properly spelled out. With labor costs high, an overemphasis on this task can eat up any savings accrued on run-of-the-mill items normally carried in stock. Let us prepare bids when we have to, but only when we believe it is necessary.

Formal bid buying has advantages and disadvantages. Now it is time to consider informal bid buying.

INFORMAL BID BUYING

Whenever a person compares a price or product of one source with a price or product of another source, he is indulging in informal bid buying. When he is preparing a study of everyday items to see what the prices will be, he can list them for himself. Rather than ask for the list to be mailed, he has the various salesmen call on him to give their prices. The salesmen will inform him of policy, discounts, stock on hand and service policy. While getting prices, the purchasing agent will be creating good dealer relationships.

From the point at which prices are listed, the buyer need only review the sources and prices to see whether someone else is offering a better price, or whether the dealer receiving the business has failed in some fashion and requires replacement. Thus, the purchasing agent has achieved all he would have achieved with a formal bid. At the same time, he has gained some information impossible to be gathered in any other way.

Under most conditions, the author favors the informal type of price and product evaluation. Formal bids under certain conditions can be used if they best serve the buyer. Whether the bid is discussed with a salesman or is written on a sheet of paper, both the buyer and the salesman must have a common ground. This common ground is the description or specification of the item under consideration. Without this bridge, no intelligent answer can be received.

SUPPLIERS WANT DETAILS

The supplier's biggest single problem in replying to requests for bid quotations is that the requests do not give accurate information. The requests may be for beds, bedside tables, overbed tables, side rails, mattresses, bed lamps, television stands, straight chairs, lounge chairs, youth beds, bedside cabinets, infant cribs and mattresses for cribs. Aside from the quantities, no additional information is given. Moreover, the due date gives little if any time for the supplier to check on the many questions that must be answered before he can make an intelligent reply.

Many hospitals currently give a description and add the phrase, "equal or better". The general effect of this is to tell the bidder that the item and source listed are what the hospital actually wants but that, if the bidder has a comparable item, he is free to quote a price on it. This ought to ensure the hospital's receiving a bid on an alternate that really is equal, as opposed to having someone slip in something that perhaps technically meets the description but that really is not as good. In short, a bid request that is not clear and definite is almost an invitation for someone to try to fool the buyer. The hospital that sends out such loose requests runs the risk of getting merchandise that it had no intention of buying.

Of course, suppliers receive many requests for quotations that are easily handled and provide adequate information. Reading from left to right across a good request form, we might find columns with the following headings: Item Number, Item and Description of Item, Unit Quantity, Specified Source (including catalogue number), "Equal or Better" (showing source and price being quoted).

Providing adequate space for the information listed, using standard easily recognized sources and providing adequate time for the return of the quotation are important. Most bidders would like to have at least three copies of the bid request. Also, the bid request should show the name of some person at the hospital who could be contacted for additional information concerning the bid.

REACHING AN UNDERSTANDING

Now let us touch upon the various classes of items we normally buy and see what information would be most vital to us and our supplier in reaching an understanding on what it is on which we seek a price.

The first class of items is equipment. Equipment is usually classified in accounts as having a certain monetary value, plus being of a permanent nature. Equipment causes the least difficulty in buying, as the hospital has specific items in mind when it issues a bid. The buyer can state that he is interested in a sterilizer of a certain capacity, run by a specific fuel and made of a certain metal. The buyer can prepare his bid by stating that this is the job to be done in the way of output of product and that he wants bids on models the suppliers believe will fill this need. Perhaps the buyer can supply the bidders with a drawing of the area where the equipment will be placed and ask that the bid be on the equipment considered best suited on the basis of performance and on adaptability to the space. In any case, the dealer needs some common ground to act upon. If this is done, the bids received will be acceptable.

General hospital supplies, such as dressings, sutures, surgical blades and catheters offer few problems in the way of preparing a successful bid. Normally, the buyer knows the product he wants and, by listing the manufacturer's number and description, he has set the limits within which he wants the bidders to act.

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In bid preparation, x-ray supplies are also "cut and dried", so to speak. The purchasing agent need only list all the specifications of the manufacturer.

BUYING PRINTING SUPPLIES

In the field of printing supplies, the buyer must use a different approach. Obviously, the hospital will have many special forms of its own. A copy of the form must be prepared and the quality of paper decided upon. Once these two requirements are met, the bidders have all the information they need.

There remains a group of items more difficult to classify. To most purchasing agents, surgical instruments have always been an enigma. Normally, they choose the historical performance technique; that is, they stipulate a brand that has worked well in their surgery department for some time. No one can be too critical of this technique, but it does put the purchasing agent into the position of not being willing to try another brand that may prove to be as good or better and perhaps costs less.

One approach to this problem follows:

The buyer states that the instruments he wants are of a specific pattern and make, or their equal. Equality in quality must be spelled out as meeting a certain metal quality and hardness on the Rockwell Scale. Now suppliers can submit bids on more than one brand of instruments. If all the quality limitations are met—and here dealer integrity is important—the buyer knows that he has purchased excellent instruments. In this field as in any other, the purchasing agent should not be blinded by brand name reputation to the point of excluding the products of lesser known manufacturers.

The field of cleaning products is so wide that it merits an entire discussion of its own. The following five factors are important:

1. Use suppliers that ship over state boundaries, as federal controls can be used for protection.
2. Be aware of solids content in relation to price. In the case of germicides, note the phenol coefficient.
3. Take note of the alkalinity of a product as demonstrated by its pH rating.
4. Study toilet bowl cleaner formulas for overacidity.
5. Insist on plastic packing as a safety factor.

In buying paper products, cups should be classified by size and type of service for which they will be used. For example, the buyer should ask for prices on a 6-ounce hot cup and let the suppliers give prices and samples. On towels, he should state whether they are to be bleached or unbleached, and he should give the basic weight per case. Toilet tissue must be described as to whether it is wrapped, bleached and the degree of softness.

Bid buying can only be useful and valuable when the buyer and the seller understand each other. Although it has certain limitations, it can be the purchasing agent's most valuable tool. ■

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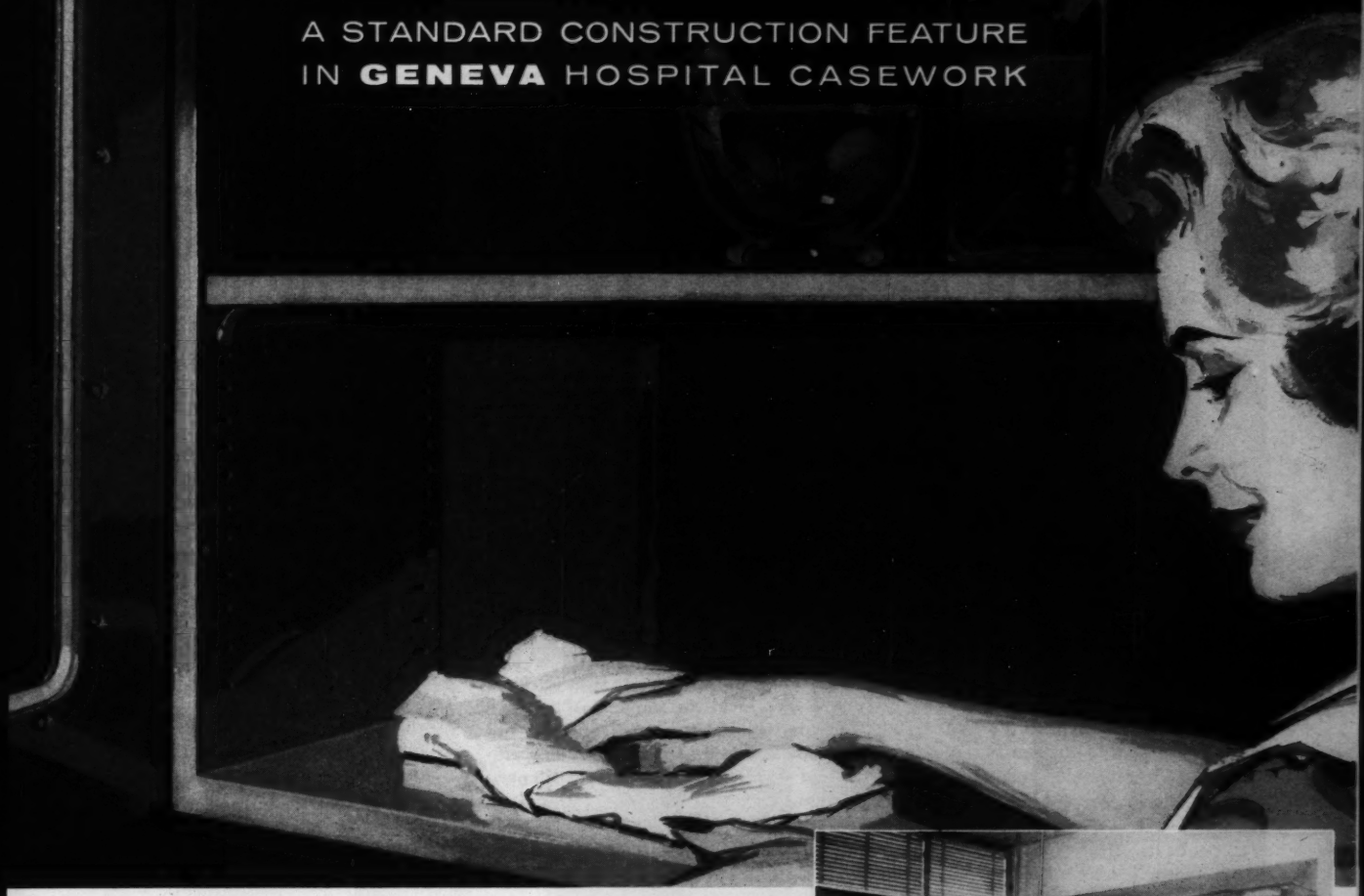

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food service and dietetics

Search for efficiency through the dietary budget

by KENNETH WALLACE

The author discusses the dietary budget as a management tool to be used in the constant search for greater efficiency of operation. He considers cost per meal an important measure of dietary department services, and points out frequent causes of less efficient operation in the dietary department.

THE ECONOMIC STRESS that institutions of all kinds are being called on to endure has aroused a new interest in operating costs. Efficiency, once an academic subject dealing with generalities, is now taking on the earmarks of a common goal which has progressed from the stage of pleasant discussion and the theories of efficiency experts to the test of delivering the goods. This search for efficiency today underlies the need for food control economy.

An important tool in achieving efficiency in the dietary department is the budget, which is an important part of the over-all hospital budget. The detailed dietary budget serves the same purpose in management of food service that the hospital budget serves in hospital administration.

Many people think of a budget as a collection of guesses. It may amount to a "guestimate" of future operations, but it can be made a very worthwhile guide both for improving service and for lowering costs.

When properly prepared, a budget becomes a "financial plan, serving as a pattern for and a control over future operations."* It should provide a "predetermined standard" by which to judge operating efficiency.

Accounting information expresses in terms of money the effect of hospital transactions. Statistics seek to measure, through quantitative data, the extent of the utilization of hospital facilities.

COMBINATION OF DATA

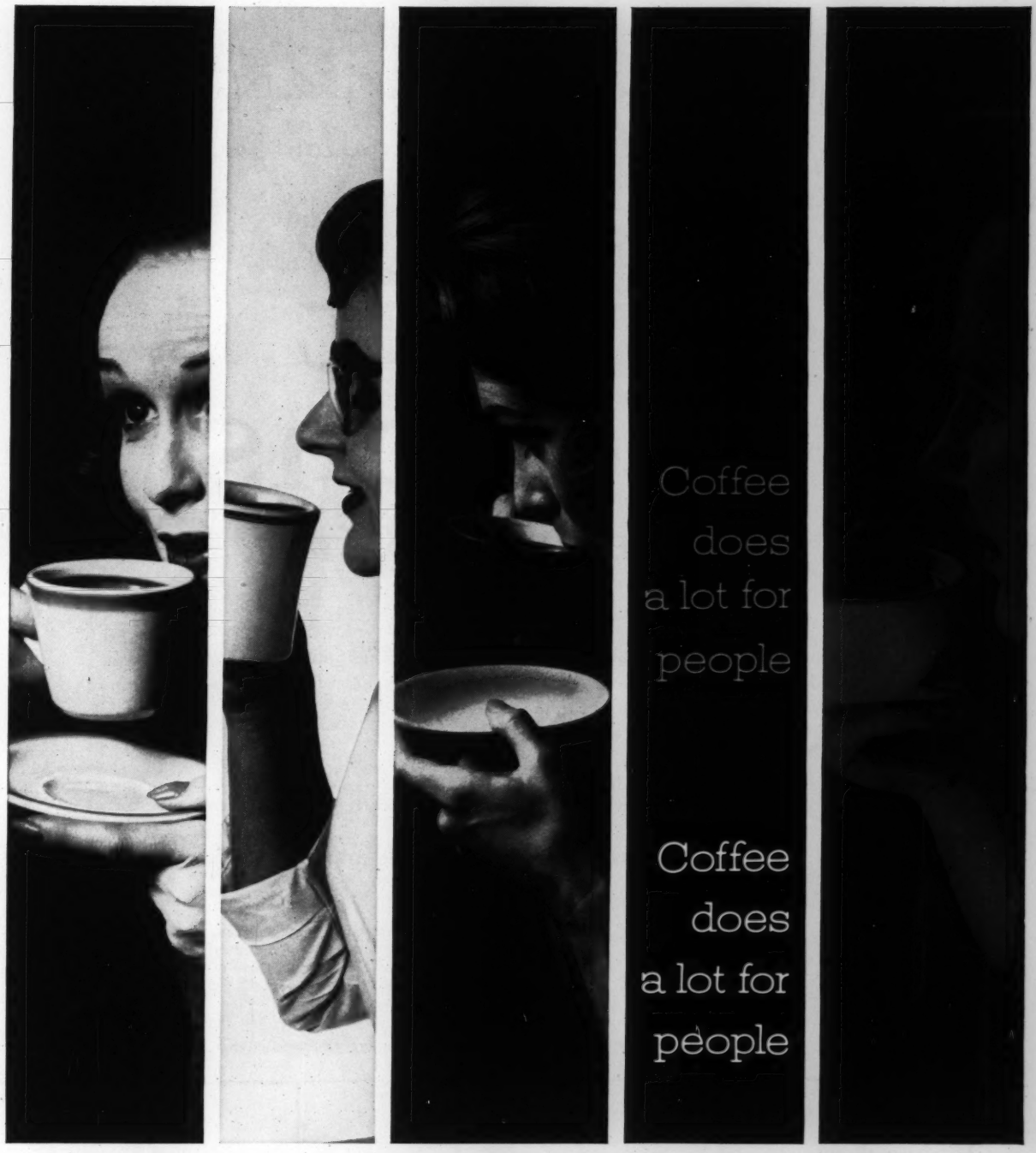
Service statistics attain their best use when they are combined with the accounting or financial data. For example, the statement of income and expense may show an increase of 25 per cent in the total dietary expense. The administrator will find it impossible to evaluate properly the significance of this financial data without service volume information. By referring to the number of meals served, the administrator may find that this figure has increased 50 per cent. Therefore, the actual result shown by both the dollar data and the service data is a significant decrease in the dietary expense per meal served. Thus, the accounting data by itself appeared to be a bad trend in operations, but by using the statistical data, a good trend appeared to be the true result.

The food service department benefits in many ways from the preparation and use of a budget. Two of these values should be mentioned. First, budgeting requires those persons responsible for the preparation of the budget to think through their problems thoroughly. Secondly, budgeting is used to compare the actual operating figures with the budgeted figures to determine the reasons for discrepancies. In other words, much can be learned about operations during the period employed in preparing a budget. Even more can be learned about operations when actual operating figures are compared with the budget figures in an effort to interpret the reasons for discrepancies.

Management should look constantly for the trends or changes taking place in operations, and should determine the nature of a trend. Management should determine whether the variance or difference between the actual and the budgeted figures is a good trend or a bad one. If a trend appears to be bad, the cause or causes for that trend should be determined. Once

Kenneth Wallace is assistant administrator, St. John's Hospital, Tulsa, Okla. This article is adapted from a presentation at an American Hospital Association Institute on Dietary Department Administration held in February 1961.

*Kohler, E. A. *Dictionary for Accountants*, New York, Prentice-Hall, 2nd ed., 1957.



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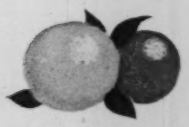

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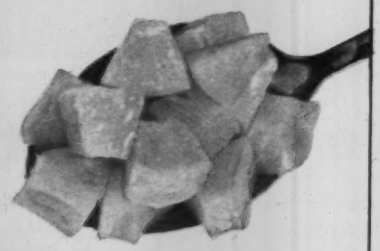

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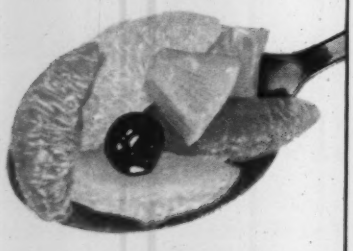

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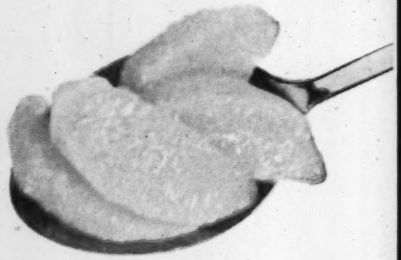

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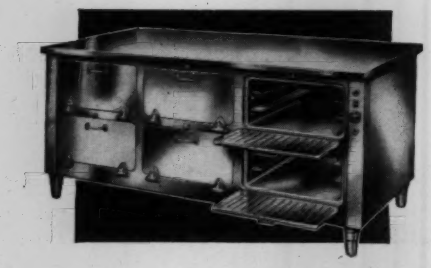

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management has found the reason for the trend, the basis for action may be evident.

FOOD AND LABOR COST ANALYSIS

In the dietary department, food and labor are the most important components of total expense.

A cumulative record of food costs permits a comparison of actual and budgeted expenditures. Such a record serves to guide menu planning and purchase control. In a hospital, the study of food cost control can be approached from many angles. Food cost per meal is one method of analyzing food cost, and is calculated by dividing the total cost of raw food consumed per period by the total number of meals served during this period.

In studying total cost per meal, direct labor cost should also be studied. Labor cost is often equal to, or more than, food expenditure. Food and labor costs can be compared from period to period. It is also interesting to compare food and labor costs with similar figures from other hospitals in relation to the total hospital budget.

One difficulty is in determining how to use the basic data to obtain a figure such as cost per meal. To obtain meaningful data, it is recommended that patient meals be separated from personnel meals. "Between meal" nourishments should be included in the total meal cost.

As in every department of the hospital, the dietary department director must think through what the figures in the budget and the dollars and cents figures of current operations mean in terms of management and service. Let us suppose that dietary costs, both as a total figure and as a cost per meal figure, have increased beyond the budgeted figures. What has caused this result? Is there a justification for this increase in terms of improved service or rising costs? Was the budget estimate poorly prepared or have operations gone out of control? To find the answer, an analysis of the operations of the dietary department should be made.

The following are some of the ways in which inefficient operation can cause food costs to rise excessively because of food waste:

1. *Overproduction of food.* Menus must be accurately planned and census conscientiously checked. Standardized recipes and portion control aid in maintaining an exact cost in the food production area.

2. *Spoilage.* Adequate storage facilities must be available for both cooked and uncooked food. A daily check of refrigerators and storerooms makes it possible to utilize leftovers and perishables.

3. *Poor food control.* Portion control is established through use of standardized recipes and serving utensils which deliver a certain size portion. Personnel should be instructed in the importance of portion control and how they can cooperate in this aspect of food management.

Two groups of data are highly important to the daily food operations:

1. *Purchasing.*

(a) The relation of market prices paid to the final cost per serving.

(b) Clearly defined standard food purchase specifications that have been developed on the basis of yield.

2. *Food preparation.* The need for utilizing standards of portion size, recipes and cooking temperatures.

PURCHASING PROCEDURES

How, then, can greater operating efficiency be attained through improved purchasing procedures? First of all, the dietitian must buy what is needed, not more than necessary. Effective food management should determine accurately the quantities of food products that must be purchased so that, as nearly as possible, the exact number of servings or portions needed will be prepared and no more. To determine the quantities accurately, it is essential to know the yield that can be obtained from each product to be purchased. Results from kitchen tests, as well as information in published food purchasing guides will indicate the yield. Such kitchen tests include butchering, cooking, tests of canned or prepackaged foods and tests of raw food.

Buying by specifications is an important aid to getting both the correct amount of food needed to

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meet the hospital requirements and the right quality of food. The specification is essentially an exact description of the food ordered. The more exact the description is, the more possible it is to know that the food received will be the quality desired and will provide the requisite number of servings. The success of standard food purchase specifications, like almost anything else, depends upon the guidance and follow-up exercised by management. This includes almost every step in dietary operations, from inspection of the food as it is delivered to serving of standardized portions.

Type of food purchased will be influenced by a continuing study of price fluctuations. In the case of seasonal items, such as fresh fruit and vegetables, quality is likely to be higher and prices lower during periods of heavy local supply.

Use of standardized recipes has been spurred by demand for a consistent product, plus rising costs, shortage of trained cooks and decentralization of food service units. Requiring the use of such recipes or formulas assures the same quality of food every time, while it permits management to control food costs. Standardization is as applicable to hospital food production as it is to the commercial cafeteria.

Often the objection is raised that the use of standardized recipes may stifle the initiative of a skilled craftsman. This objection can be overcome if the personnel using the recipes are encouraged to initiate new recipes and to make suggestions for improving the recipes and the recipe system.

SEARCH FOR SAVINGS

Thinking through the dietary budget in terms of how the daily operations may contribute to the search for lower costs and better service is an individual matter in each hospital. The check list below gives only a few examples of points to look for:

Equipment

1. Are there clocks in kitchens for cooks to check cooking time?
2. Are dippers, spoons, whips and knives available for the cooks?
3. Are range ovens in good working order?
4. Is the peeler frequently overfilled?

Storage Space

1. Is the diet kitchen refrigerator being used?
2. Are vaults tidy? They will be untidy when everyone has access to them. Is there supervision of the vaults?
3. Is the salad refrigerator used to store vegetables for salad preparation?
4. Are frozen vegetables and fruits stored in the freezers near the vegetable or bakery units?
5. Are there opened cartons of milk in the milk refrigerator?

Issuing of Supplies

1. Are recipes for controlling quantities used by cooks? Are cooks allowed to draw from the storeroom indiscriminately?
2. Are bread ends saved?
3. Is a definite quantity of dry milk used in products requiring milk?

Time Element

1. Do cooks go to the storeroom area and wait for all supplies and ingredients?
2. Do cooks walk to the vegetable preparation unit to chop vegetables for seasonings?
3. Do cooks walk around the range island to use the roasting ovens?
4. How much time is consumed by taking cooked foods to the preheating area of the hot carts?
5. What are the ordering schedules for meat, produce and other supplies? Can they be ordered fewer times per week or month? If these supplies are not delivered as ordered, menus may have to be changed.
6. Are stencils for all menus being retyped each week, thus increasing the work of the secretary?

Cooking Methods

1. Are vegetables overcooked and cooked too far in advance? Also, are they left standing for periods of from one to three hours?
2. Are vegetables all being cooked at one time, causing crushing and unsatisfactory appearance and taste?
3. Are meats cooked at high temperatures, causing shrinkage and toughness?
4. Are steam kettles boiling over?
5. Are the cooks trained to use the French knife properly?
6. Are turkeys being cooked whole rather than boned and rolled, causing approximately 10 per cent more shrinkage?
7. Is there a planned use of leftovers? Are they being discarded rather than refrigerated for reuse?

The dietary budget should be considered as an aid to improving service as much as a means of controlling or lowering costs. The best possible service to patients is the aim of every hospital department. In the dietary department, this means serving meals so appetizing that the patient is pleased and so nutritious that his recovery is speeded. Through the cold dollars and cents figures of the dietary budget, the dietitian can find help in achieving this goal. ■

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NOTES AND COMMENT

Today's new foods and tomorrow's kitchen

A number of speakers at the meeting of the Illinois Dietetic Association, April 13 and 14, 1961, told of developments in precooked foods that foreshadow revolutionary changes in dietary departments.

Lendal H. Kotschevar, Ph.D., School of Hotel, Restaurant and Institutional Management, Michigan State University, dramatized what changes in food production will mean to hospital food service of the future in the title of his talk, "Is the Kitchen Going to Go?"

"Boil-in-bag" foods, frozen entrees, freeze-dried foods, and other precooked foods may take much of the food production out of the institutional kitchen. The convenience foods of today are only a hint of what may come.

Mr. Kotschevar characterized the food service industry, one of

FROZEN ENTREES for institutional food service are now being marketed in a few test areas. The baked fish shown above is a square of baked boneless Boston cod topped with herb-seasoned dressing and a white wine sauce. Available in quantity packs in frozen form, the fish comes in an aluminum tray and the wine sauce in a plastic bag. The entree may be heated in an oven or steamer.

the largest industries in this country, as a handicraft industry which never went through the industrial revolution. He said increase in productivity in the food service industry has lagged behind that in other industries.

Because of this lag, according to Mr. Kotschevar, the food service industry is unable to pay wages as high as other industries, and suffers the consequence in high turnover and absenteeism. What wage increases have occurred have not been compensated by increased productivity; consequently in the price of institutional meals, the ratio of food cost has declined, while the ratio of labor cost has risen.

Mr. Kotschevar described some new processes used in freezing foods which permit retention of structure and flavor. Instant freezing and a method to remove all oxygen from gravies and sauces ("sparging") greatly reduces oxidative changes and the mixing of flavors. Frozen entrees and "boil-in-bag" foods prepared by these methods are already on the market to a limited extent.

Freeze-dried foods differ from frozen foods in that they may be kept at ordinary temperatures and need not be held in frozen storage. These foods are dried while in the frozen state. They may occasionally show some toughening during processing, but undoubtedly the quality will improve as time goes on.

"Man is the product of what he eats, in more ways than the obvious. Ever since man became man, a breakthrough in food processing or preparation preceded each major step up the ladder of civilization. Because it has been so throughout history, it is likely to be true in the accelerating tomorrow."— ***from "Menu for Tomorrow" by Richard D. Mathews and John P. Nielsen, Stanford Research Institute,*** **SRI Journal,** ***First Quarter 1961.***

Dehydro-freezing is another process for foods of the future. In this process, approximately 70 per cent of the moisture is removed before freezing. Foods prepared by this process must be kept in frozen storage until used. Saving of volume and weight in these products is one of their advantages.

Considerations of quality and cost will help to determine whether these new foods succeed in the institutional market. In order to determine the quality of these new foods, standards must be set up by which to judge them, according to the speaker.

The cost of some of the new foods seems high when compared by conventional means of calculating food costs. Actually not all indirect food costs are taken into account in calculating the cost of food production. For example, the dietitian's time in initiating and super-

vising food production may not be considered.

Will food products suffer from a monotonous sameness when these precooked foods are used extensively? Mr. Kotschevar thinks not, and illustrated with slides how a dietary department can differentiate its product and achieve individuality by variations in the dish, garnishes, and accompanying menu items and by distinctive decor, table service and interior decoration.

Mr. Kotschevar predicted that these new foods will tend to take food production out of the hospital dietary department and put it into factories where modern techniques to increase efficiency can be utilized.

Virgil Wodecka, Ph.D., director, Food Division, Quartermaster Food and Container Institute for the Armed Forces, discussed in detail the new dehydrated or "freeze-dried" foods which achieve their superiority over earlier processes by being dried while frozen.

The advantage of this process is that the water "sublimes", or passes directly from the frozen state to a vapor state, and the structure of the product is maintained. Volume of many foods dehydrated by this method is about the same as of the original food, but weight is considerably reduced. When water is added to prepare the food for use, the water enters the same spaces it occupied in the unprocessed fresh food.

These dehydrated foods do not require refrigerated storage. Mr. Wodecka claims for them the convenience of canned foods, with a taste comparable in many items to that of frozen foods.

The army is interested in these foods because of their advantages for any military operation in the future when the principles of mobility and dispersion would be expected to intensify the need for ready prepared individual rations. Their light weight is also an advantage that may lead to their use in early short manned space flights where they may be used with recycled water.

Mr. Wodecka stated that the Quartermaster Corps has produced on an experimental basis complete daily rations that need only hot water for getting the meal ready to eat. Meat, fruits, vegetables and "one-dish" meals are used in these rations.

Many of the same qualities that make these foods appealing to the military—their light weight, ease of preparation and good flavor—also make them promising products for homes and institutional kitchens. The army is interested in seeing the process become popular commercially, since only with a well developed commercial industry will this method of food preservation be practical on a large scale for the armed forces, according to Mr. Wodecka.

Already on the market are some foods processed by this method—dehydrated soups, shrimps and a chicken-rice product.

Members of the Illinois Dietetic Association had an opportunity after Mr. Wodecka's talk to taste some of the products now available commercially as well as some of the foods now prepared for experimental army rations and to attest to their good flavor. ■

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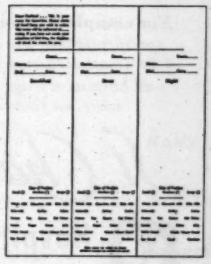

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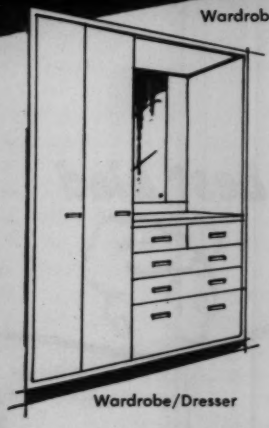
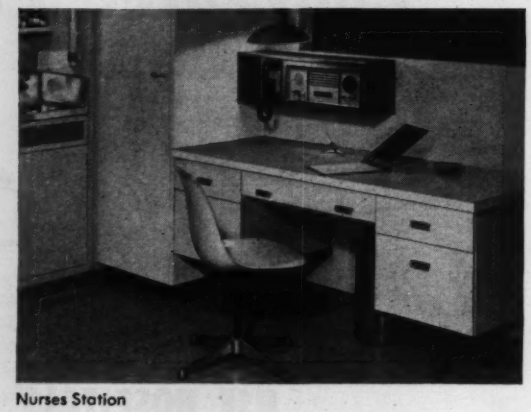


Wardrobe/Dresser

Wardrobe/Lavatory



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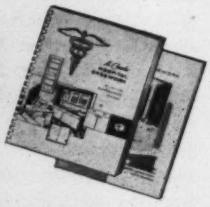


St. Charles

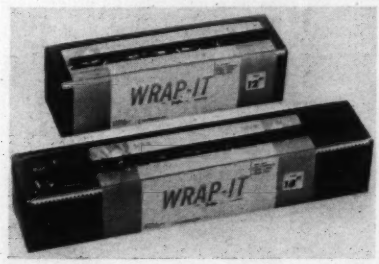
Hospital Casework Systems

St. Charles Mfg. Co., Dept. H-6, St. Charles, Ill.

equipment and supply review

Packaging film (11F-1)

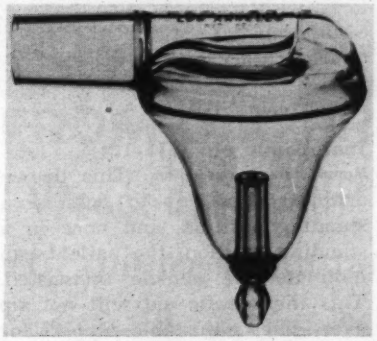
Manufacturer's description: Dispensed in a cutter box containing 1000 ft. of packaging film, this product is available in 10-, 12-, 16- and 18-in. rolls. The film may be used to cover pans, bowls, fresh fruits, gifts, etc. For convenient handling, the rolls are packed three to a



case. *Roll-O-Sheets, Inc., Dept. H11, 9444 Watson Industrial Pk., St. Louis 26, Mo.*

Plastic nebulizer (11F-2)

Manufacturer's description: This nebulizer has a jet which produces a



fine mist, does not spill when tipped and keeps nebulizing when tilted at any angle. The device does not clog easily, is easy to clean, withstands rough usage and is available in either pyrex or plastic. *Hudson Oxygen Therapy Sales Co., Dept. H11, 2801 Hyperion Ave., Los Angeles 27.*

Hospital chair (11F-3)

Manufacturer's description: Designed to fit the contour of the average person, this chair is constructed of leather grained plastic and is available in turquoise, white, persimmon and charcoal. The chrome-plated frames are available in eight colors, with the chair standing 30½-in. high and weighing

only eight lbs. *Fixtures Mfg. Corp., Dept. H11, 1641 Crystal Ave., Kansas City, Mo.*

Mobile coffee dispenser (11F-4)

Manufacturer's description: This stainless steel, table-top coffee dispenser features the coffee storage compartment under the serving faucet, enabling the faucet to be the only protrusion above working height. The working area is almost completely unobstructed. Since the unit is on wheels, it can be moved anywhere for service. The dispenser can be plugged into any electric outlet, or it can rely on the heavy

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____Packaging film (11F-1)
_____Plastic nebulizer (11F-2)
_____Hospital chair (11F-3)
_____Mobile coffee dispenser (11F-4)
_____Floor lamp (11F-5)
_____Uretheral catheterization pack (11F-6)
_____Medical utility gloves (11F-7)
_____Patient-handling unit (11F-8)
_____Flatwork stacker (11F-9)
_____Therapeutic aid (11F-10)
_____Paraplegic wardrobe unit (11F-11)
_____Water pitcher (11F-12)
_____Infant and childrens' cast table (11F-13)

PRODUCT LITERATURE

_____Electrical code bulletin (11FL-1)
_____Electric control center (11FL-2)
_____Hospital control of drugs (11FL-3)
_____Portable precision incubator (11FL-4)
_____Oscillograph instruments (11FL-5)
_____Surgical instrument holders (11FL-6)
_____Resuscitator catalogue (11FL-7)
_____Quantity recipes (11FL-8)

NAME and TITLE _____

HOSPITAL _____

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(Please type or print in pencil)

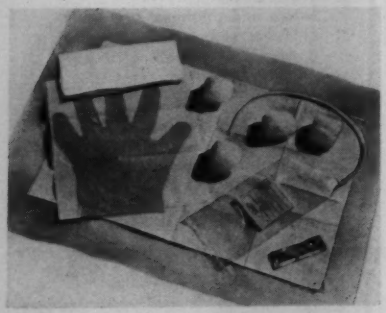
insulation to keep coffee hot when unit is mobile. Also, the dispenser can be used for iced tea by filling part of the storage tank with crushed iced and adding tea concentrate. *S. Blickman, Inc., Dept. H11, 536 Gregory Ave., Weehawken, N.J.*

Floor lamp (11F-5)

Manufacturer's description: Designed to give excellent lighting for close examination, the lamp head eliminates breaks or short circuits, is perfectly balanced and the weighted base makes it difficult to topple. A heat and chip-proof, white plastic shade adjusts for proper reading illumination and the electrical outlet and on-off switch are at mattress level so that patient and nurse can reach both with ease. The model adjusts on double vertical posts from 47 to 56½ in. above the floor, with a night light in the vertical post which reflects light to floor, but will not bother the patient. *American Hospital Supply Corp., Dept. H11, 2020 Ridge Ave., Evanston, Ill.*

Uretheral catheterization pack (11F-6)

Manufacturer's description: In addition to being disposable, another feature of the catheterization pack is the 500 cc. collection bag attached to a Robinson 14 French smooth plastic catheter. After collection, the bag can be clamped shut, forming a sealed, leak-proof container for carrying the specimen to pathology



or to a disposal point. Also included is a patient identification sticker and clamp, which can also serve as a waste wrapper after the catheterization procedure; a pair of prepowdered gloves, a perineal drape, four cotton balls, an application of lubricating jelly and an outer wrap that can be used as a sterile field on which to prepare the component parts. *Sterilon Corp. Dept. H11, 500 Northland Ave., Buffalo 11.*

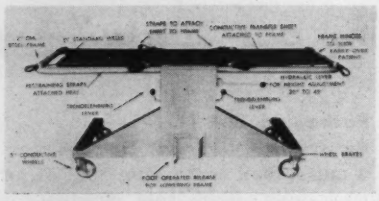
Medical utility gloves (11F-7)

Manufacturer's description: Safeguarding of hands in regard to specific functions in the hospital are provided by these red utility gloves which feature a knit-cotton lining that is permanently bonded to a rubber coating. The gloves are 14½-in. in length, provide flexibility and are resistant to oils, greases and most acids. The gloves also aid in insulation from hot and cold tempera-

tures, keep hands dry and free from irritating substances, have a nonslip finish and are available in small, medium and large sizes. *Pioneer Rubber Co., Dept. H11, 396 Tiffin Rd., Willard, Ohio.*

Patient-handling unit (11F-8)

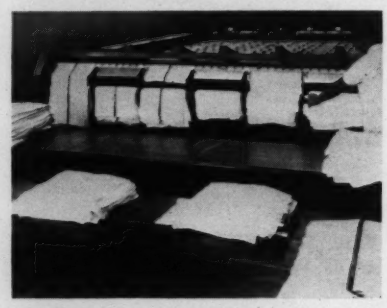
Manufacturer's description: This unit enables hospital patients to be transferred from one department to another or from bed to bed without having to be lifted. The patient is placed on a conductive sheet; the unit is rolled up; the sheet is attached to the unit, and the patient is lifted by hydraulic power. As the conductive sheet does not affect the clarity of x-ray pictures, the patient need not be taken off the sheet during x-ray procedure and the entire unit is engineered to fit under and over hospital beds, surgical tables and x-ray machines with the height hydraulically ad-



justable from 30 in. to 45 in. *Simmons Co., Hausted Div., Dept. H11, Medina, Ohio.*

Flatwork stacker (11F-9)

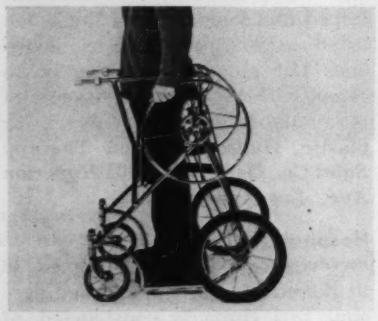
Manufacturer's description: Fully automatic, this stacker places flatwork directly from the ironer, can be



applied to any 120-in. flatwork ironer and is available with four, five or six stacking lanes. Pieces can also be by-passed in any or all lanes without stacking so that use of the ironer is not limited to work which is stacked. *American Laundry Machinery Industries, Dept. H11, Cincinnati 12.*

Therapeutic oid (11F-10)

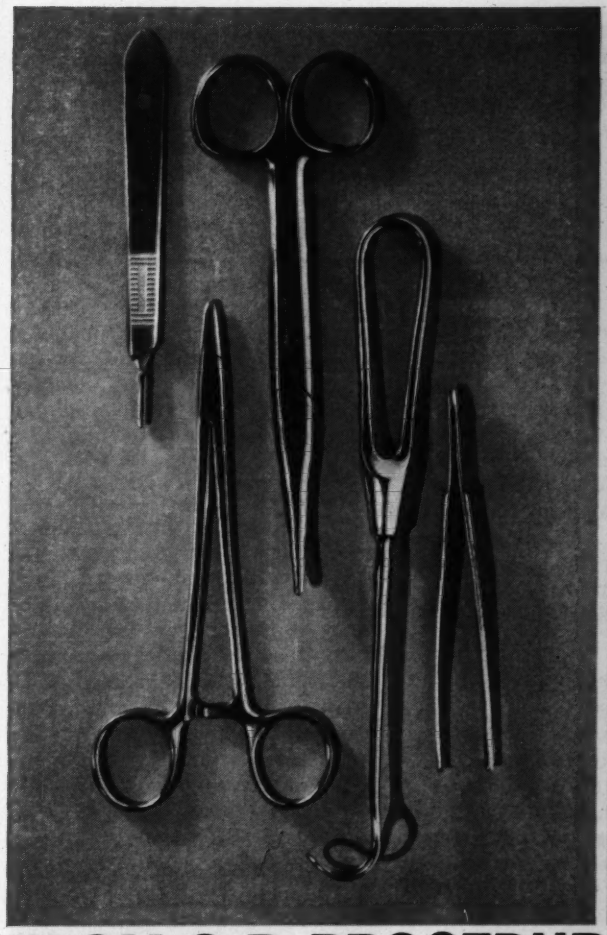
Manufacturer's description: This device enables a patient to achieve a standing position, and once in a standing position, the patient can motivate the vehicle unassisted. This therapeutic aid will not tip over, gives adjustable support for patient when standing and folds

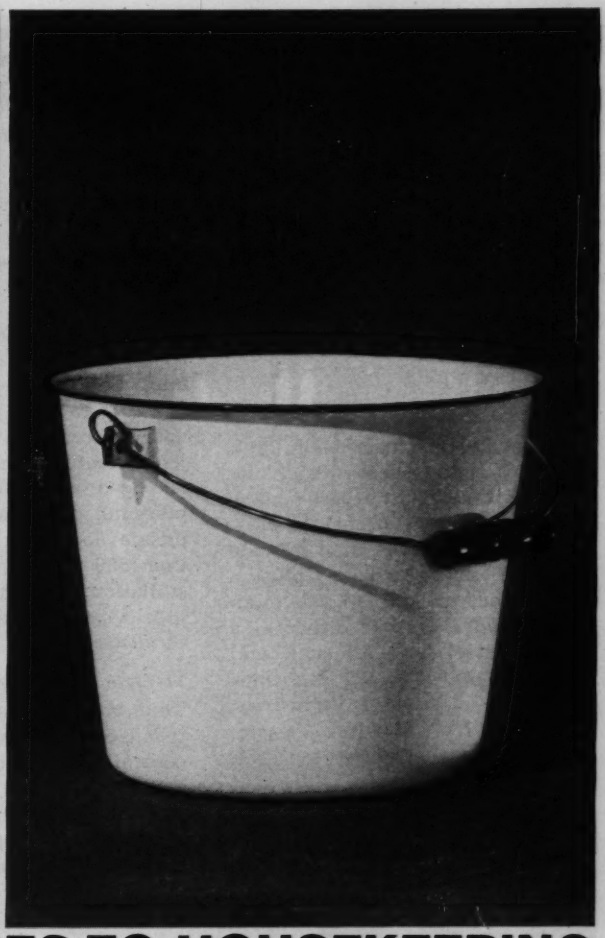


compactly for transporting. *Jean Medical Products Sales Co., Dept. H11, 447 Hidalgo Ave., Alhambra, Calif.*

Paraplegic wardrobe unit (11F-11)

Manufacturer's description: Available in





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12 colors, this compact 54-in. high steel unit is equipped with a rubber kick plate at the base and is movable on institutional casters. Two sections of the unit provide adequate storage space, plus a hanger rod, towel rack and tooth brush holder. Three drawers, a stainless steel pull-out shelf and a chrome-plated guard rail complete this unit. *Nellis Industries, Inc., Dept H11, McClure, Snyder Co., Pa.*

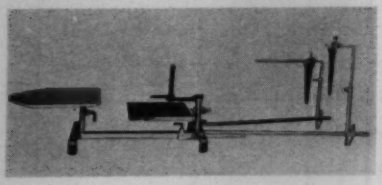
Water pitcher (11F-12)

Manufacturer's description: Packaged

four to a carton and made of aluminum, this 2½-qt. water pitcher contains an ice bridge to facilitate pouring beverages. In addition, the pitcher is constructed of lightweight 20-gauge aluminum and weighs just 4 lbs. to a shipper. *Enterprise Aluminum Co., Dept. H11, Massillon, Ohio.*

Infant and childrens' cast table (11F-13)

Manufacturer's description: This orthopedic traction cast table, designed



for infants and children, is compact and light weight. It may be easily transported wherever necessity demands in the hospital. It is impervious to water, will not warp, is easily cleaned of plaster and may also be used in offices and clinics, as well as in the hospital. *Zack Rogers Assocs., Inc., Dept. H11, 5 Broadway, E. Paterson, N.J.*

product literature

SEE COUPON, PAGE 79

Electrical code bulletin (11FL-1)—A 60-page publication detailing the applications of condulets in hazardous locations, plus code articles and recommendations for condulets meeting the various code requirements. A reference for planning electrical installations in unsafe locations, including more than 300 product illustrations, installation photographs and drawings. *Crouse-Hinds Co., Dept. H11, Syracuse 1, N.Y.*

Electric control center (11FL-2)—This booklet describes the electronic control center as a compact, centralized climate control station. It is a custom designed control panel that graphically illustrates a building's entire air conditioning system. The electronic control center can detect mechanical equipment failures, accidental equipment shutdowns and uncomfortable space temperatures. *Barber-Colman Co., Dept. H11, Rockford, Ill.*

Hospital control of drugs (11FL-3)—Illustrated in this booklet is a complete system of equipment, supplies, forms and procedures for drug control. This system, by means of automation, provides pharmacy, nursing and accounting services with many benefits; as well as providing the same benefits to patients, medical staffs and management. *Brewer Pharmacal Engineering Corp., Dept. H11, 9138 West Chester Pike, Upper Darby, Pa.*

Portable precision incubator (11FL-4)—Designed specifically to incubate test specimens at a constant specified temperature in the clinical pathology and biochemical laboratories, this booklet describes a fluidless, precision incubator that can be used in blood banks and hematology laboratories, as well as in clinical chemistry; including amylase, lipase and phosphatases. In serology it can be used for inactivation of serum and complement fixation tests. *Thermolyne Corp., Dept. H11, 465 Huff St., Dubuque, Ia.*

Oscillograph instruments (11FL-5)—An illustrated product digest with a brief description of standard products and general performance information. Also, a description of both wet-process and direct-readout oscillographs, galvanometers, bridge balance units, galvanometer amplifiers, and a complete line of ground-station telemetry instruments and electro-hydraulic servo-valves. *Midwestern Instruments, Inc., Dept. H11, P.O. Box 7509, Tulsa 18, Okla.*

Surgical instrument holders (11FL-6)—Booklet contains detailed drawings of scissors and stainless steel jaws for tungsten carbide needle holders. Also included are the size and description for each needle holder and the type of surgery for which each is used. *Snowden-Pencer Corp., Dept. H11, P.O. Box 186, Los Gatos, Calif.*

Resuscitator catalogue (11FL-7)—Items listed in this 20-page catalogue are divided into two groups: units that employ the Kreiselman principle of manual intermittent positive pressure and units which operate on the E & J principle of automatic positive-negative pressure. *Ohio Chemical Co., Dept. H11, 1400 E. Washington Ave., Madison 10, Wis.*

Quantity recipes (11FL-8)—This 38-page booklet contains a collection of 65 quantity recipes, including ideas for the preparation of appetizers, breads, desserts, beverages, salads and relishes, to name just a few. *Processed Apples Institute, Inc., Dept. H11, 30 E. 40th St., New York, N.Y.*

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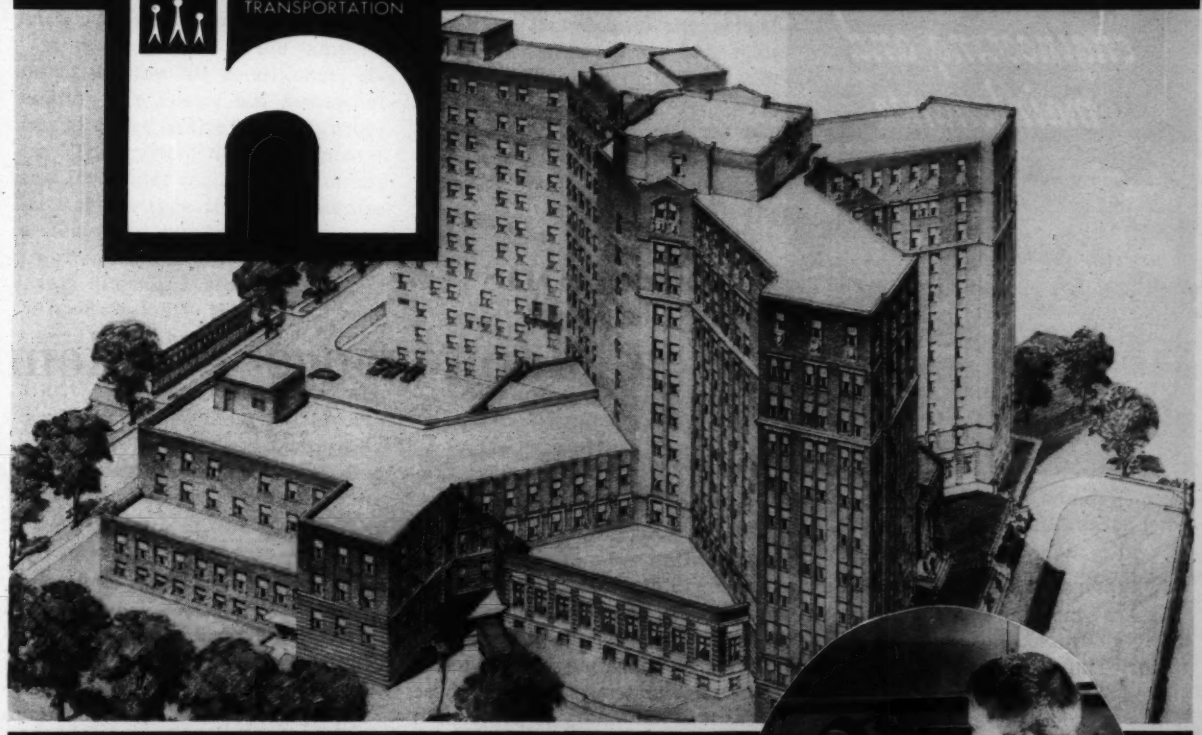

Hurley Hospital, Flint, Mich. One of America's leading municipal hospitals, it provides accommodations for 707 patients. It is served by eight Haughton elevators and four Haughton dumbwaiters—all protected by a continuing program of Haughton Maintenance-Monitor Service.

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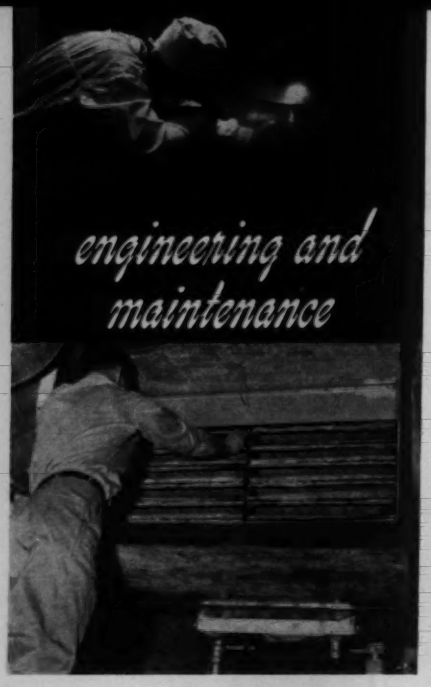


Infections as a Maintenance Problem

by GEORGE E. LINNEY

"STAPHYLOCOCCUS" has become a scare word in the mind of many a harassed hospital administrator. The stubborn antibiotic resisting *Staphylococcus aureus,* once it has invaded the sterile sanctum of today's hospital, can cause untold havoc.

The hospital engineer, through a well established preventive maintenance program that will ensure good sanitation and infection control, assumes a key position on the team that fights this ever-threatening menace.

His is a 24-hour on-the-job and on-call responsibility. Unfortunately, this microscopic organism and other potential sanitation hazards do not confine their endeavors to the usual 8-hour day, 40-hour week. Such a program of preventive maintenance and control must be strategically planned to combat any possible invasions around the clock. It must be a preventive program, not one that frantically "shuts the barn door after the horse has been stolen."

HOSPITAL AIR SYSTEMS

The modern hospital is not simply heated in the winter by a steam convector or radiator system without consideration for ventilation or systematic change of air. In most areas of the United States, air conditioning of hospitals is a "must" in operating rooms, delivery rooms and nurseries. In these areas it is customary to provide an all fresh air system; that is, one in which there is no recirculation of air. We may be approaching the day when it will be safer to recirculate air from these areas through greatly improved filtering systems than it will be to introduce so-called fresh air from the outside. In fact, in all but the special areas mentioned above, as much as 90 per cent of the air is recirculated in the modern air handling system.

This recirculation of air and the introduction of fresh air from the outside calls attention to the theory of air-borne bacteria. Bacterial contamination is possible via both air and water. With water, however, there is some assurance of control, since water to a great extent is confined to a closed system. It is more difficult to confine the medium of air, since we literally live in an ocean of it.

The hospital engineer must consequently take extra precautions in operating and maintaining air handling equipment in order to provide for the patient a plentiful supply of air relatively free from bacteria at all times. This is brought about by efficient housekeeping of air handling equipment, better still by the scientific filtration of air through a modern air filtering system. Such a system may include an electronic air filter strategically located in the intake of principal air ducts.

FRESH AIR SYSTEM SAFEST

Air-conditioning systems available to hospitals are of several types. For the operating rooms and other sterile areas, the low pressure duct system with 100 per cent air change and no recirculation is still regarded by most authorities as the safest. The electronic air filter is readily adaptable to this system. A high pressure duct system may serve patient rooms and other less sterile areas of the hospital, permitting some recirculation of room air. In this system, it is again possible to use the central electronic air filter.

Patients' rooms are now being air conditioned by convectors of the fan and coil type, in which chilled or hot water is supplied to the unit from a central water cooling and heating system. This unit introduces a small amount of outside air through an opening in the outer wall of the building, recirculating most of the room air by means of a small self-contained fan. All air, both outside and recirculated, passes through a filter

George E. Linney is administrator of Griffin Spalding County Hospital, Griffin, Ga.

of porous material in the unit. This filter is either disposable or permanent and washable. Either type may be treated with an effective bactericidal solution.

A third system is the conventional window air conditioner, effective as a cooler but somewhat less effective in the filtration process. This system makes no provision for winter requirements unless it is of the type that incorporates a steam coil supplied from a central heating plant.

Air filtering systems, regardless of how efficiently they may be designed, are only as effective as the hospital maintenance program permits them to be. Consequently, the hospital engineer must be instructed and fully informed concerning their operation and should develop a periodic inspection and servicing schedule for them in his preventive maintenance program.

SANITATION PROBLEMS

In the interest of good sanitation, the engineer must answer promptly all calls from nursing units and other departments which may need his immediate attention. Such calls, frequently involving stopped up commodes, drains, sewers, etc., obviously must be attended to without delay. Repetition of these difficulties may call for a thorough investigation of the systems by the engineer (perhaps with the help of the local sanitary inspector) to ascertain if any corrections in the systems are needed.

The engineer must assure himself that the hospital is being furnished potable water from a chemically treated supply. Control of such systems is usually under the supervision of the community water works, but the hospital engineer nevertheless must be satisfied that adequate control is being maintained.

It goes without saying that the hospital engineer must be familiar with local, state and national plumbing codes, since he is often called upon to install or relocate fixtures in an existing building. These codes specify the size of drain lines, vent stacks, fall and distance of these from fixtures, etc. They point out the precautions to be taken in the installation and operation of syphons, ejectors, etc.

Steam sterilizing equipment, as simple as it is in design and construction, can give trouble and must be included in the periodic inspection of the preventive maintenance program. Sterilizers develop faulty exhausts and may be supplied with insufficient steam pressure due to regulator difficulties. Even automatic controls are not infallible and must be checked periodically.

ULTRAVIOLET LAMPS

From time to time, there has been much argument concerning the effectiveness of ultraviolet germicidal lamps in combatting airborne bacteria. One recent article* cites the effective usage of this type of sterilization in operating rooms both by direct and indirect radiation and by installation of this type of equipment in air ducts supplying these and other sterile areas of the hospital. Lamp maintenance is important. Ultraviolet lamps "must be cleaned and periodically replaced to insure maximum efficiency of the installation." "Lamps should be turned off and washed with alcohol once a month to remove accumulated grease and dirt." This informative article states further, "If the ultraviolet output . . . is less than 70 per cent of the published values for that lamp, the lamp should be replaced." Fixtures, as well as lamps, should be cleaned. Dust filters, replaced periodically, should precede ultraviolet lamps in air ducts.

Most hospitals, particularly those which have been built within the last 10 to 12 years, are equipped with the most modern facilities to ensure good sanitation and infection control. The effectiveness of these facilities is often lessened by an inadequate maintenance program. This phase of an engineer's duties cannot be overemphasized.

THE INFECTION COMMITTEE

The hospital engineer should be an active participating member of the hospital infection committee. This committee, depending on the size of the hospital and the incidence of infection, can be divided into two subcommittees, one composed of chiefs of services and professional department heads and known as the professional subcommittee; and the other composed of heads of hospital service departments, including housekeeping, laundry, maintenance, etc., and known as the hospital services subcommittee The engineer is in this latter group. Depending on the incidence and magnitude of infection in the hospital, recommendations from the professional subcommittee are transmitted to the hospital services subcommittee for improvement of areas of the hospital and checking of systems under the jurisdiction of the engineer.

In some smaller hospitals, the engineer may be in charge of housekeeping and laundry operations as well as building and mechanical maintenance. This arrangement places a great deal of the responsibility for control of infections under one head. In the very large hospitals, these service departments may be under the direction of an administrative engineer.

RESPONSIBILITIES DURING CONSTRUCTION

In contemplating a new building or new additions to an existing building, a hospital board of trustees should appoint the hospital engineer as consultant to the architect and to the building committee. In this capacity, he can familiarize himself with the details of design and construction and ascertain for himself that installation of the various systems is in accordance with codes governing them. The engineer is usually familiar with construction materials that will eliminate "dust catchers", "bacterial breeding grounds", etc. The favorable consideration of these materials early in the planning stages will pay off in the long run by reducing housekeeping and maintenance costs and will help to keep infection at a minimum.

The patient comes to the hospital to be cured, if possible, of his malady; certainly not to contract a new one during his stay. The role of the hospital engineer in fighting infection and maintaining good sanitation is important. ■

*Air sanitation with ultraviolet light. *Air Engineering*, October 1960.

book reviews

Casebook on decisions

also:
Guide to board efficiency
Nursing and staphylococcal infections

DECISION MAKING IN HOSPITAL ADMINISTRATION AND MEDICAL CARE: A CASEBOOK. James A. Hamilton. Minneapolis, University of Minnesota Press, 1960. 710 pp. $10.50.

The use of the case-study method in the teaching of administration has become an accepted and valuable technique in recent years. Dr. Hamilton's book is a casebook written primarily to help graduate students of hospital administration and of medical care administration learn to make wise decisions, and to assist educators in teaching this complex art.

A brief introduction discusses the teaching of administration and makes specific suggestions on how the cases can be used in the curriculum. The cases themselves constitute the bulk of the text. They are divided into three major types of problems: (1) problem definition exercises, (2) problem solving exercises and (3) comprehensive cases—all presented in order of increasing complexity.

A series of curbstone cases is also presented, to be used as a sort of mental arithmetic. The cases have been accumulated since 1946 by the faculty of the graduate program in hospital administration at the University of Minnesota and, as the reader will quickly sense, represent actual experience.

Although primarily intended for students enrolled in universities, the book is an obviously invaluable tool for inservice training programs. The practitioner of hospital or medical care administration will profit greatly from the book, once he eliminates the feeling of envy that will probably overcome him when he sees how easily today's students are able to obtain a lifetime's experience, which he had to work through painfully on a trial-and-error basis.

The situational factors presented in each instance are those that we may tend to forget as being influential, after our minds have settled comfortably into our patterns of thinking. For anyone interested in decision-making and problem-solving in hospital administration, the cases will read like a series of very good mystery stories, to which each reader must apply his own solutions.

The book is indexed by type and subject of case, thus lending itself to quick and easy reference.—MARK BERKE, *director, Mount Zion Hospital and Medical Center, San Francisco.*

Guide to board efficiency

THE EFFECTIVE BOARD. Cyril O. Houle. New York, Association Press, 1960. 174 pp. $3.50.

How to Be a Good Board Member might be the subtitle of this book. As a textbook and guide for board members and prospective board members of voluntary organizations, including hospitals, it should be most useful.

The author, professor of education in the University of Chicago, has for some years conducted a course for training board members. This course is sponsored jointly by the University and the Welfare Council of Metropolitan Chicago. The benefits of this course are now made available to a much wider group of interested people.

An idea of the contents can best be given by mentioning a few of the subjects dealt with, including how to select board members, the proper size of the board, length of tenure, responsibilities of a board member, relationship between the board and the staff, and others.

The number of people serving on the boards of voluntary associations is very large and constantly increasing. Most of them, however experienced they may be, would benefit from a careful reading of this book.

The author places a great responsibility on the chairman of a board. A board chairman plays an important role in the success or failure of any organization, and hospitals are no exception. Is he competent? Does he inspire confidence? Does he use the manpower of his group to the best advantage? Does he promote the development of other potential leaders in the group? Is he successful in promoting good relations with the professional staff? These qualities mark the true leader, which every group must have to achieve its purpose.—JEAN O. AYLEN, *President, Ontario Hospital Association.*

Nursing and staphylococcal infections

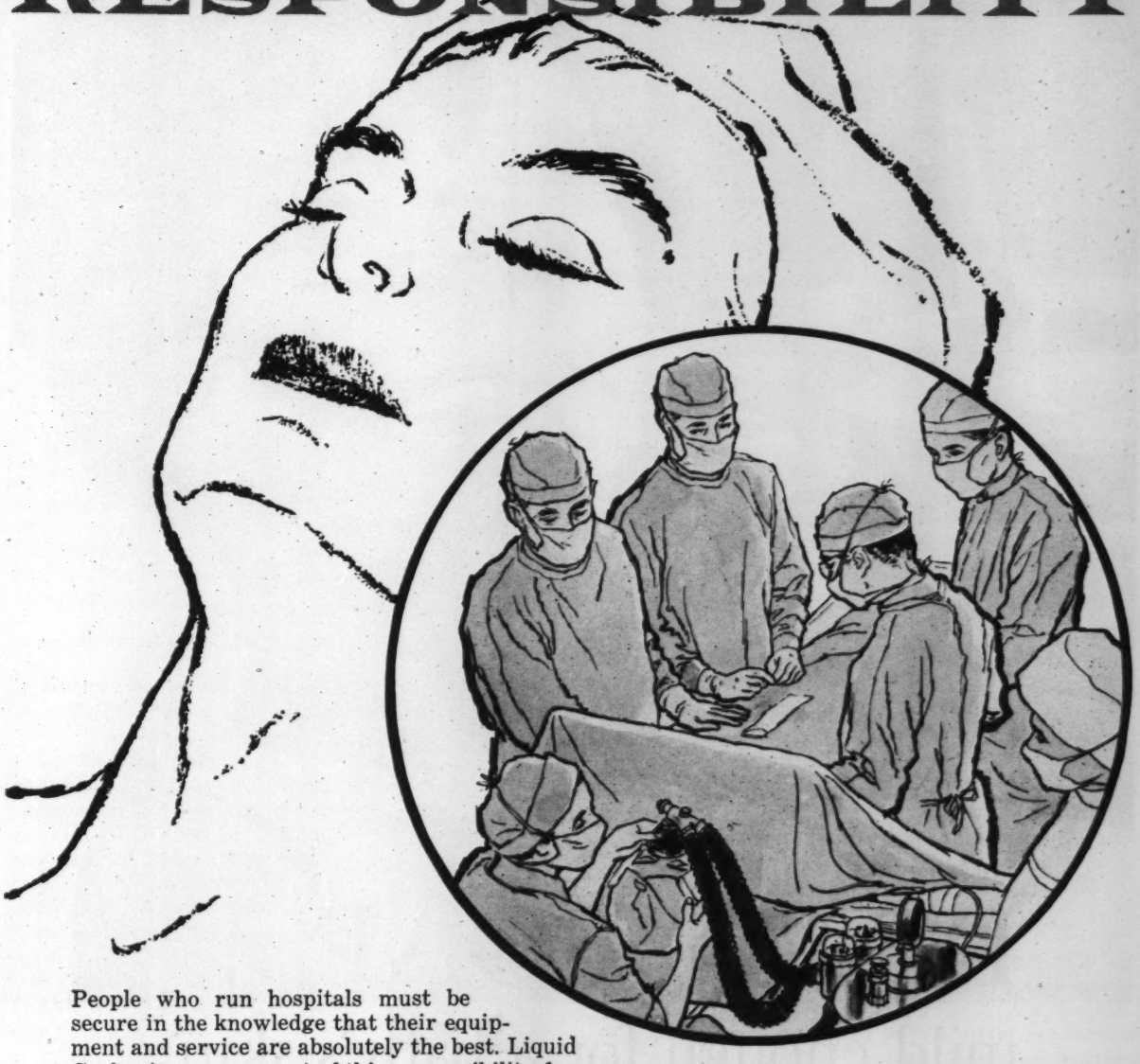
A third volume of selected materials on staphylococcal infections has been published by the Communicable Disease Center of the U.S. Public Health Service in Atlanta, Ga.: *Staphylococcal-Disease: Selected Materials on Nursing Aspects.*

This compilation includes 22 contributions from various hospital, medical and nursing publications and five appendixes: (1) Selected readings relating to the nursing aspects of hospital infections . . . ; (2) Bibliography of staphylococcal infections and other relevant subjects of special interest to nurses; (3) Audiovisual aids relating to hospital infections . . . ; (4) American Hospital Association Bulletin: Prevention and control of staphylococcus infections in hospitals, and (5) a special report of the Committee on Fetus and Newborn of the American Academy of Pediatrics: Suggestions for control of staphylococcal infections in newborn nurseries.

This publication, No. 764 in the Public Health Service Publication Series, is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., for $1.

The two earlier collected papers are: *Selected Materials on Staphylococcal Disease, No. 627,* and *Selected Materials on Environmental Aspects of Staphylococcal Disease, No. 646.* These are also available from the Superintendent of Documents, the first for $1.25 and the second for $1.50. All orders must be prepaid.

RESPONSIBILITY



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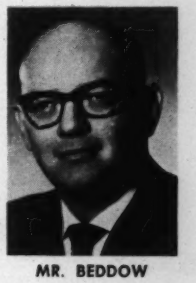
personnel changes

● The appointment of **John P. Bachman, M.D.,** superintendent and medical director of Seaside Hospital, Waterford, Conn., to the position of superintendent and medical director of Cedarcrest Chronic Disease Hospital, Newington, Conn., has been announced by the commissioner of the Connecticut State Department of Health. Dr. Bachman replaces **Reginald C. Edson, M.D.,** who was recently named deputy commissioner, Office of Tuberculosis Control, Hospital Care and Rehabilitation. Dr. Bachman came to Connecticut in 1956 as medical director of the Connecticut State Welfare Department. Dr. Edson, a graduate of Jefferson Medical College, Philadelphia, joined the Connecticut Tuberculosis Commission in 1942.

● **John H. Beddow** has been named assistant to the president for hospital administration at New York Medical College, Flower and Fifth Avenue Hospitals, New York City. Mr. Beddow last served as executive director of the Chronic Disease Hospital, Brooklyn, N.Y.



MR. BEDDOW

● **Mrs. Ruth Bruening** (see Ditto item).

● **Oliver E. Deehan** has been named administrator of the Palo Alto-Stanford Medical Center, Palo Alto, Calif. He has been acting administrator of the hospital since the resignation of **E. Dwight Barnett, M.D.,** last June. Mr. Deehan first joined the hospital as associate administrator in 1957 and was promoted to deputy administrator in 1959. He holds a master of science degree in hospital administration from the Columbia School of Public Health and Administrative Medicine.

MR. DEEHAN

● **Elmo A. Derrick** (see Eason item).

● **Mike W. Ditto** has been named administrator of the Arlington (Tex.) Memorial Hospital. He succeeds **Mrs. Ruth Bruenig,** who died recently. Mr. Ditto has been business manager of the hospital since 1957.

● **Elwood R. Eason** has been appointed administrative assistant and night administrator at University Hospital and Hillman Clinics, University of Alabama Medical Center, Birmingham. A graduate of Duke University Medical Center School of Hospital Administration, Mr. Eason replaces **Elmo A. Derrick,** who has been appointed administrative assistant and director of outpatient services.

● **Reginald C. Edson, M.D.** (see Bachman item).

● **Thomas R. Felion** has been appointed to the newly created position of associate administrator of St. Joseph's Hospital, Marshfield, Wis. Mr. Felion has been an assistant administrator at St. Vincent's Hospital, Erie, Pa., for the past five years. He is a graduate of the school of business administration and the course in hospital administration at the University of Minnesota.

● **Donald M. Furbush** was recently appointed administrative services assistant for the Alameda County Medical Institutions, Oakland, Calif. Mr. Furbush received his master's degree in hospital administration at the University of Chicago.

● **Elbert E. Gilbertson** has been appointed administrator of St. Luke's Hospital, Boise, Idaho. He has been serving as assistant administrator and personnel director of the hospital, and previously served for two years as staff consultant with James A. Hamilton Associates, Minneapolis, Minn. Mr. Gilbertson is a graduate of the course in hospital administration at the University of Minnesota. He succeeds **Mrs. Helen B. Ross, R.N.,** who resigned after 16 years as administrator of the hospital.

Special Notes

▸ **Herbert L. Flack,** assistant director of Jefferson Medical College Hospital and assistant professor of Hospital Pharmacy at the Philadelphia College of Pharmacy and Science, has been named the 1961 recipient of the Harvey A. K. Whitney Lecture Award. Established in 1950 by the Michigan Society of Hospital Pharmacists, the award is presented annually to an individual who has made outstanding contributions to American hospital pharmacy.

▸ **William A. Hacker,** administrator at McKeesport (Pa.) Hospital was honored recently at a testimonial luncheon marking his 40 years of service at the hospital. Mr. Hacker was presented with a silver tea service and a check from the hospital's board of trustees. He expressed his gratitude for "the cooperation I have received as hospital administrator."

▸ **Clifton J. Latiolais,** president of the American Society of Hospital Pharmacists, was the recipient of the first Geigy Leadership Award. The award, sponsored by the Geigy Pharmaceuticals, Arsdale, N.Y., was created to honor practitioners of hospital pharmacy for demonstrated qualities of leadership, and will be presented to all presidents of affiliated chapters of the society.

▸ **C. Thomas Smith Jr.** has been awarded the Carl A. Erikson Fellowship in Hospital Administration at the University of Chicago for 1960-61. Mr. Smith received his bachelor's degree from Baylor University in Waco, Tex. The fellowship is awarded annually to a student in the graduate program on the basis of his potential in the field of hospital administration.

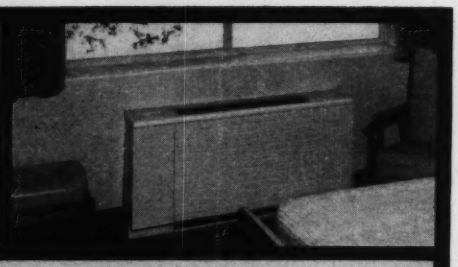
Lutheran General Hospital,
Park Ridge, Illinois.

Architects:
Burnham & Hammond.

Consulting Engineers:
E. R. Gritsch & Associates.

General Contractors:
William E. Sweitzer & Co.

Heating Contractor:
Thomas J. Douglass & Co



Crane Fan-Coil units fit the temperature to the patient all year 'round in this 316 bed hospital

New Lutheran General Hospital has some of the most advanced design features of any hospital in the country. It has year 'round air conditioning throughout — provided by Crane fan-coil units. These remarkable units automatically heat, cool, control room temperature. Have individual thermostats in every room. Give patients personalized comfort in any season. And there are no ducts to carry bacteria, noise or odors between rooms. Units operate quietly. Do not interfere with radio or television reception. Can be installed either free standing (as shown above) or recessed in walls or ceilings.

Crane fan-coils keep costs down. Each one operates independently. You can turn them off in unoccupied rooms. And because expensive ductwork is eliminated, installation costs are lower, too.

Each unit contains a heat transfer coil, a motor and two quiet blower fans. They are connected to a central boiler and water chiller. Use either steam or hot water for winter heating . . . chilled water for summer cooling. It's the cleanest comfort there is.

Lutheran General Hospital is heated by two super-efficient Crane 500 H.P. Cyclotherm steam generators that also meet its extensive needs for domestic hot water and steam for sterilizing.

For more details on Crane fan-coils and other plumbing, heating and air conditioning equipment for hospitals, see your architect or contractor. Or write Crane Co., Box 780, Johnstown, Pennsylvania.

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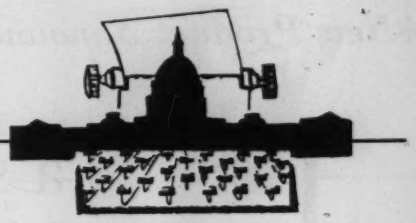

House Approves $4.02 Billion for HEW in 1962

A record $4.02 billion approved by the House Appropriations Committee for the Department of Health, Education, and Welfare was passed, without amendment, by the House (H.R.7035) May 17. The appropriation included a new allotment of $10 million for grants for construction of hospital research facilities. These grants, which would be administered outside the Hill-Burton hospital construction program, were not requested by the Kennedy Administration in its budget for HEW. They have also been opposed in American Hospital Association testimony to the 87th Congress.

The recommended HEW appropriation put the funds for Hill-Burton activities at $187,972,000. This was the exact amount requested in the Kennedy budget. Hill-Burton figure breakdown was: $185 million for construction purposes; $1.2 million for hospital and medical facilities research, and $1,771,000 for administrative expenses. The $185 million and $1.2 million figures are identical to those appropriated for fiscal year 1961. AHA has asked Congress to raise the $1.2 million ceiling on research funds to $8 million.

For the National Institutes of Health (NIH), the House Appropriations Committee recommended $641 million for fiscal year 1962. This was $58 million more than requested by the Kennedy Administration and $81 million more than the current fiscal year appropriation.

The new $10 million for grants for construction of hospital research facilities was approved by the House committee under section 433 (A) of the Public Health Service Act. This little-known section of the act, which is completely separate from Hill-Burton provisions, gives the Public Health Service Surgeon General authority to make certain types of grants for facility construction in connection with NIH programs.

The House committee added the $10 million after hearing testimony from private hospital institutions on an experimental hospital research unit indicating a possible sharp cut in nursing care costs. AHA testimony on such a program was presented to the House Committee on Interstate and Foreign Commerce in hearings on the proposed Community Facilities act. AHA said there already is "ample provision" under Hill-Burton for "construction projects developing new types of design."

The House Appropriations Committee funds recommendations are now scheduled for Senate consideration.

House Committee to Hold Aged Health Care Hearings

Congress will hold hearings this year on the Kennedy Administration aged health care plan. This has been announced by Rep. Wilbur Mills (D-Ark.), chairman of the House Ways and Means Committee. He stated in May that, following consideration of President Kennedy's tax proposals, his committee would hold hearings on H.R.4222. This is the Administration bill introduced by Rep. Cecil King (D-Calif.), which is a companion to S.909, sponsored by Sen. Clinton Anderson (D-N.Mex.). Pending since February 13, the Anderson-King measures call for social security financing of specified days of hospital, nursing home and home health services and outpatient diagnostic care for senior citizens.

Kerr-Mills Act Payments Show Steady Increase

Vendor payments under the Kerr-Mills Act are showing a steady growth, according to figures recently obtained from the Department of Health, Education, and Welfare. The latest tally was for February 1961. Five states were then participating: Massachusetts, Michigan, Oklahoma, Washington and West Virginia. Payments totaled $3,852,628 for 18,678 recipients—an average of $206.27 per recipient.

In comparison, the average for the initial month, November 1960, was $191.06 per recipient. Three states were then participating: Massachusetts, Michigan and West Virginia. The total vendor payments were $2,255,660 for 11,806 recipients.

Tax Deduction Bill Favorably Reported to House

Pending on the House calendar in mid-May was a tax bill significant to hospitals. It had been favorably reported out of the Ways and Means Committee the previous week.

H.R.2244, introduced by Rep. A. S. Herlong Jr. (D-Fla.), deals with income tax deductions. Under present law, an individual may deduct up to 20 per cent of his adjusted gross income for charitable deductions, and in addition, up to 10 per cent for contributions made solely to churches, educational institutions, hospitals and certain medical research organizations. H.R.2244 would extend the additional 10 per cent deduction for contributions to an exempt charitable trust or foundation organized and operated solely for support of churches, educational institutions, hospitals and medical research organizations.

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Prednisone or prednisolone	5 mg.
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THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Nurses and Intravenous Medication

Whether nurses are legally qualified to administer intravenous medication is a matter of state law. In few states has there been an official pronouncement on this subject, and the formal opinions which do exist are not uniform in their conclusion. A recent opinion of the New York attorney general, however, should be influential in clarifying the controversial points.

In 1942 the then attorney general ruled, "I am informed that the consensus of opinion in the medical profession does not favor the administration by nurses of medication by the intravenous route because of the inherent dangers to patients involved." He added, "However, it may be that specially trained registered nurses might properly administer intravenous medication under supervision and order of graduate physicians in cases of extreme emergency; but not where complicating factors necessitate minor operations, such as incision to reach a vein."

1942 OPINION REVIEWED

The commissioner of the New York State Department of Health requested an opinion of the incumbent attorney general in December 1959. Emphasis was placed on the advances in medical and nursing science since 1942 which would indicate the need for a revision of the prior opinion. Attorney General Louis Lefkowitz counseled with qualified leaders in medicine, nursing, public health and hospital fields. He then examined the medical and nursing practice laws. Mr. Lefkowitz, in his opinion of March 6, 1961, explained that his predecessor did not err; his view was consistent with existing medical opinion but he anticipated a broader interpretation of the statute when the medical problems were resolved.

1961 OPINION

The current opinion is predicated on the principle of statutory construction that "all legislation . . . is to be interpreted in the light of the social and economic conditions of its time, and where the previous construction took place so long ago as to have become antiquated, it need not be followed". The writer deemed significant:

—the advances made in the art of healing and the techniques developed in the practice of medicine and nursing

—the change in attitude of the medical profession towards intravenous therapy by nurses

—the statement by the commissioner of health that intravenous procedures which involve vena puncture by needle but do not require incision into (or incision to reach) a vein can be performed safely by properly trained nurses and without danger to patients.

Although the medical and nursing statutes allow flexible interpretation, incisions to reach a vein seemed clearly the practice of medicine and not to be permitted to nurses, the opinion relates. The giving of intravenous injections by a registered nurse had been authorized by a 1952 opinion of the counsel to the state education department, if the nurse is under the supervision of a physician, but not if the nurse acts independently. In this regard, Mr. Lefkowitz emphasized:

"It is for the physician alone to determine whether an intravenous procedure should be administered and whether an intravenous procedure could be administered properly by a specially trained registered professional nurse. . . . It is my understanding that a registered professional nurse does not possess necessarily by virtue of her license the technical skill to carry out intravenous procedures."

Consequently, it was recommended that schools of nursing in New York include intravenous procedures in the curriculum, and

"I suggest further that the hospitals and other nurse-employing agencies in this state establish in-service training programs adequate to qualify and insure the competence of those registered professional nurses, already licensed, whom the medical profession may direct to carry out the intravenous procedures to which this opinion expressly is limited."

OPINIONS IN OTHER STATES

Thus New York is now following the path established in a few states which have recently considered who may indulge in intravenous procedures.

- Alabama: The attorney general found no precedents in the law and concluded that this was a proper subject for control by the state medical board. The latter announced approval of the training of nurses in venipuncture and administration of drugs in this fashion under the supervision of a licensed physician. In this way authority was established.
- Michigan: An opinion of the attorney general has interpreted the nursing practice act to allow a licensed nurse to give intravenous medication as prescribed by a physician.
- Florida: The State Board of Nurse Registration

This material is not legal advice. The information on this page should not be used to resolve legal problems. For advice on such problems a hospital should consult a member of the local bar.

published an excerpt from an American Medical Association legal opinion as guidance for determining the occasions when nurses may administer intravenous therapy. Stressed were the necessity of supervision or direction by a licensed physician as well as special training and qualifications of the nurses for such procedures.

• California: In the absence of clear legal guidelines, the professional organizations concerned with nursing service have agreed to a statement governing the administration of intravenous medications by nursing personnel. It provides that registered nurses may start and administer fluids intravenously if (1) the nurse has special competence and training in the technique, (2) the procedure is performed only on order of a licensed physician and for a specific patient, (3) within the hospital there is a special committee representing medical and nursing staffs to prepare written rules and to supervise the training of nurses for these skills. This joint statement does not have the force of law but it is likely to be respected by any court which may be considering the legality of intravenous therapy as conducted by nurses.

• Pennsylvania: A statement similar to that of California has been agreed to by the medical society, hospital association, osteopathic group, state league for nursing and the nurses' association. It covers the administration of fluids intravenously by registered nurses and their withdrawal of venous blood.

NEW JERSEY IS DIFFERENT

An exception to the liberal trend in this field is the 1959 ruling of the New Jersey Board of Nursing. It recognized that nurses usually do not receive instruction in intravenous procedures during their schooling. Therefore, it concluded that in the interest of the public, the preparation and administration of intravenous therapy is not a function of nurses. The board resolved that even where a nurse may have received special training and where a licensed physician directs her to administer intravenous medication, if a nurse is to do these acts she must perform under the immediate supervision of the physician and in his presence.

In California, blood is considered a "fluid". A recent survey in that state indicated that adverse reactions to blood are likely to become evident within five to seven minutes from commencement of the transfusion. During that period it would be desirable to have a physician present so that corrective action, which might constitute diagnosis and treatment, would not devolve upon a nurse. The same survey showed that introduction of a needle into a vein is not a dangerous procedure when performed by trained nurses. It is an adverse reaction to the fluid which is far more troublesome; hence the need for a written procedure requiring routine checking of the patient during the course of the intravenous treatment. A few California hospitals apparently have used laboratory technicians, licensed vocational nurses, and unidentified "others" to administer intravenous fluids. It must be pointed out that although a technician or person other than a registered nurse may take a blood sample, he is not authorized to participate in intravenous procedures.

Almost half the California hospitals reporting disclosed that they used registered nurses for infusion of blood. If this percentage prevails elsewhere in the country, it would be preferable for the representatives of hospitals, nursing, and medicine in each state to adopt a statement for guidance in establishing inhospital administration of intravenous fluids. The California and Pennsylvania approach discussed above would be appropriate in most states where no statute or legal opinion provides direction. The patients as well as the doctors, hospital administration, and hospital personnel would be well served by this procedure.

Blue Cross May Choose Hospitals

Must a Blue Cross plan make payment for hospitalization in any hospital listed by the AHA? This was the problem in a newly decided Texas case. *Van Court v. Group Hospital Service, Inc.*, S.W. 2d (Tex. Civ. App., March 23, 1961). The patient was hospitalized in an institution not approved by the plan. He assigned his interests to the hospital and litigation resulted when the plan refused payment.

The relationship between a subscriber and the Blue Cross plan is contractual. The terms of their agreement determine when payment will be made. In this case the policy authorized payment for care received in "member hospitals"; i.e., hospitals with which the plan had a contract. Treatment in nonmember hospitals would be compensated only (1) in case of accident, (2) if the hospital is "registered" with the American Medical Association, or (3) if the hospital is approved by the plan.

ARE LISTING AND REGISTRATION THE SAME?

The plaintiff-patient was not an accident case and the hospital had not been approved by the plan. The controversy centered around the AMA's defunct registration program. The AMA ceased to register hospitals in 1954. This function was taken over by the AHA which established the practice of listing hospitals. The hospital involved in this case was established in 1954 and acquired a listed status. The plaintiff contended that as long as the hospital met listing requirements, he was entitled to payment for his hospitalization; listing was the successor program to registration and AHA listing was tantamount to AMA registration, especially since this hospital was too new ever to have been registered; otherwise the language about registration in the contract must be void because it is impossible of performance.

The appellate court upheld the trial court's verdict. The contractual language allowed of a reasonable interpretation. Since there is no longer a hospital registration program, a nonmember hospital would be paid by Blue Cross only if approved by the plan. This hospital was not approved and as a consequence, the plan was not obligated to make payment.

(Continued on page 103)

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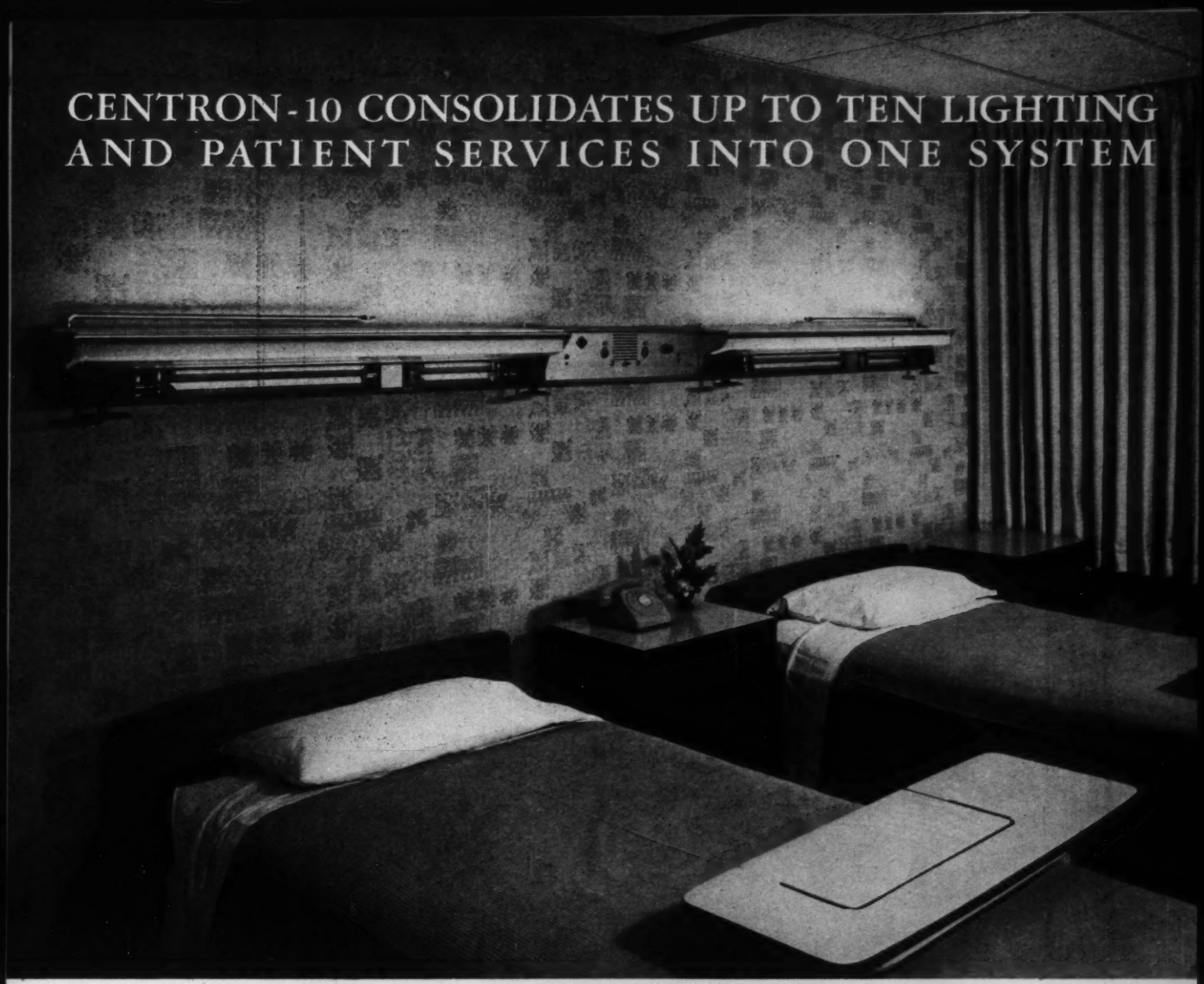

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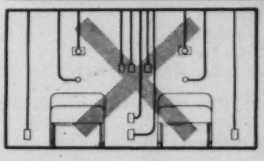

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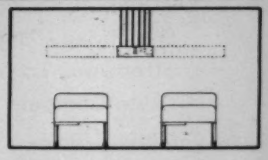

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IN CHICAGO—

Increased Utilization and Cost of Hospital Care Topics at Annual Tri-State Hospital Assembly

A continued increase in the use of hospital facilities and in the cost of hospital care was forecast at the opening session of the 31st annual Tri-State Hospital Assembly in Chicago, May 1-3. More than 8500 delegates from hospitals in Illinois, Indiana, Michigan and Wisconsin attended the three-day conference.

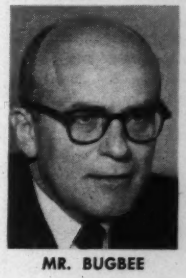
George Bugbee, president, Health Information Foundation, New York City, and former executive director, American Hospital Association, keynoted the session with an analysis of present and future trends in the hospital world entitled "Broader Horizons in the Field of Health and Welfare."

Mr. Bugbee said the change in the composition of the population, with an increasing proportion of persons over 65 years of age, will contribute to the greater total need for health care. He predicted that the hospital will tend to become more a center of long-term care with a wider range of organizational services.

At another session, representatives of the medical staff, trustees, and Blue Cross dealt with the problems of malpractice and its impact on patients, physicians and hospital administration. John F. Horty, director of the Health Law Center, University of Pittsburgh, said that hospitals' legal problems are "growing all across the board." The malpractice situation is becoming worse, he said, because hospitals are looked upon by the public as large corporations, able to pay damage suits. He said there is a connection between legal problems and litigation in malpractice suits in all states, because malpractice problems are not limited to the individual hospital, medical staff or employee, but rather, are problems of the state.

SHOULD INFORM PATIENTS

Jack Masur, M.D., president-elect of the American Hospital Association, Assistant Surgeon General and director of the Clinical Center of the National Institutes of Health, Bethesda, Md., said in his discussion of the medical aspects of malpractice suits that well-informed patients rarely sue the physician. He called for more detailed routine admittance and consent forms, more detailed information supplied by the physician



MR. BUGBEE

DR. MASUR

to the patient and a written statement from the patient stating his knowledge of the risks involved, as means of lessening the problem.

Bert Howard, M.D., assistant executive vice president, American Medical Association, in a session on the effect of federal legislation in financing health care for the aged, said it would affect the freedom of the private physician and would change the patient-physician relationship. Dr. Howard said states should step up Kerr-Mills legislation because there is no adverse effect on private physicians under it. Under the Forand Bill, he said, there is no difference in approach between those individuals who need financial help and those who do not.

Kenneth Williamson, director of the Washington Service Bureau, American Hospital Association, said there is no "panacea" for hospitals in a federal-administered program for financing health care for the aged. Social security, he said, will affect hospitals in three ways: (1) utilization, (2) administration and (3) financing. He explained that the aged will seek more care under the program, placing more stress on hospitals, that hospitals will have to provide information about the program under the legislation, and more aged will want care in hospitals without physician reference, and finally, the federal government will be unable to provide full cost for the hospital care.

The associate director of a research project on patients' expectations of hospital, medical and nursing care told a conference of nurses and administrators that established modes of "categorizing" patients can hinder patient care and should be re-evaluated.

'GOOD' BEHAVIOR MISLEADING

Daisy Tagliacozzo, Ph.D., department of patient care research, Presbyterian-St. Luke's Hospital, Chicago, reporting on a year-long research project, said that many hospital patients are "good" patients because they fear "being considered inconsiderate" and arousing the nurses' hostility. She reported that many patients come to the hospital with preconceived notions. They view the hospital as another example of a large organization, and think of doctors and nurses as impersonal and overworked. The patient "by and large, does not take his safety for granted," she said, and he may be trying to "save" the services of the nurse for a time when he may *really* need them. Consequently, she pointed out, the behavior of a patient may not be a good guide to his needs.

Catherine M. Norris, R.N., director of nursing, Illinois State Psychiatric Institute, said that it is one thing to be able to "spout the right theory," but it is another to put it into practice. She said that every hospital teaches that patients are all different, yet hospital rules do not allow the theory to be practiced.

SHORTAGE A 'MYTH'

Lead-off speaker in the Federal Hospitals session on manpower shortages, John M. Danielson, administrator, Evanston (Ill.) Hospital, told administrators that the shortage may be a "myth." He gave the following assumptions as a basis for his statement: (1) hospitals may be employing too many people; (2) the largest number of employees seems to be in the professional area; (3) few standards have been set for these professional people; (4) employees are not well enough trained, and (5) hospitals do not select and pay employees with enough discretion.

Kenath Hartman, administrator, Chicago Wesley Memorial Hospital; Col. Margaret Harper, R.N., chief, Army Nurse Corps, Office of the Surgeon General, Department of the Army, and Gabriel Ferraz-

zano, M.D., deputy chief, Division of Hospitals, Bureau of Medical Service, U.S. Public Health Service, were members of the panel on "Newer Concepts of Progressive Medical Care." Mr. Hartman said "we don't have a (manpower) shortage, but we need better utilization" of what we have. He said that progressive patient care is expensive because it calls for two employees for every patient and payroll costs are rising every year.

MR. HARTMAN

Col. Harper called for greater emphasis to be given to "doing with" patients rather than "doing for" them. She said that progressive patient care makes it possible for the personnel best suited for each area to meet the particular needs of each patient.

GEARED TOWARD STRENGTHS

Speaking on the application of progressive patient care in public health service hospitals, Dr. Ferrazzano said, ". . . the hospital routine under progressive patient care is directed toward the strengths and abilities rather than toward weaknesses, limitations and handicaps." Progressive patient care enables the administrator to implement staffing, and to allocate funds and other management functions more realistically, thus discouraging proneness toward puting too much in some areas and not enough in others, he said.

A plea for the application in hospitals of rehabilitative techniques for the early management of the hemiplegic patient was made by Edward E. Gordon, M.D., director, Department of Physical Medicine and Rehabilitation, Michael Reese Hospital, Chicago. He emphasized the part that the nurse can play in initiating the early steps toward rehabilitation, and urged that a nurse trained in rehabilitation be a member of all hospital nursing education staffs.

Tri-State Awards of Merit—

Wisconsin: Riley McDavid, administrator, Kenosha Hospital

Indiana: Olive M. Murphy, R.N., Bartholomew County Hospital, Columbus; past-president, Indiana Hospital Association

Illinois: Leon C. Pullen Jr., former administrator, Decatur and Macon County Hospital; partner in the firm of Dr. Herman Smith, Hospital Consultants, Chicago

Michigan: Ella K. Longley, superintendent, Paulina Stearns Hospital, Ludington

Past-President's Key—

Roger B. Nelson, M.D., associate director, University Hospital, Ann Arbor, Mich.; president, Tri-State Hospital Assembly

Among the awards presented at the assembly were the Tri-State Awards of Merit and the Past-President's Key (see box, above). A gift was presented to Albert G. Hahn and Grace O. Hahn, executive secretary and associate executive secretary respectively of the Tri-State Hospital Assembly, in honor of 25 years service to the Assembly. Dr. and Mrs. Hahn are administrator and assistant administrator, Protestant Deaconess Hospital, Evansville, Ind. ■

IN KANSAS CITY—

Opposing Views Aired on Aged Medical Care At 33rd Mid-West Hospital Association Meeting

Opposing views concerning the Kerr-Mills Act and President Kennedy's plan for medical care for the aged were expressed by Nelson H. Cruikshank, director of the Department of Social Security, AFL-CIO, and Frank S. Groner, president of the American Hospital Association, at the 33rd Mid-West Hospital Association annual meeting. The meeting was held in Kansas City, Mo., April 26-28.

Mr. Cruikshank, proponent of the Kennedy plan, said he addressed the group not just as a "labor spokesman," but in behalf of all American consumers of hospital care. "All that we consumers want," Mr. Cruikshank declared, "is that hospitals should be responsive to the challenge of the times. President Kennedy has proposed a very simple program under the social security system whereby people can contribute, while they are working, toward health benefits at the time of retirement—including hospitalization, nursing care and outpatient diagnostic service."

The most "flagrant evidence" of the extent to which some hospitals are out of tune with the people they are designed to serve, Mr. Cruikshank contended, is "the craven stand many hospital spokesmen feel it necessary to take on the issue of health benefits for America's aged."

Asserting that the Kerr-Mills Act cannot meet the need for any but a small segment of America's aged, Mr. Cruikshank said it should be regarded only as supplemental health protection. Organized labor is not against the Kerr-Mills program, he said, and it would not advise any state not to implement the Kerr-Mills Act. But it would be a mistake, he asserted, to place sole reliance on what is properly a supplementary program. In the seven states represented in the Mid-West Conference, less than 14 per cent of the people over 65 residing in these states would have medical assistance under the Kerr-Mills Act, he said.

Frank S. Groner, in a rebuttal speech, said the real issue behind President Kennedy's plan and the Kerr-Mills Act was essentially that of local authority versus federalism. "The trend is moving toward Washington," he declared, "and we will need to decide whether we are going to have a central, monolithic form of government." He pointed out that the Kerr-Mills Act provides federal assistance, yet leaves control of funds expenditure to the states.

MR. GRONER

Mr. Groner strongly affirmed the view that our main concern should be what is good for the people of this nation, and what is good for patients. "With government the purchaser of so much hospital care, cost will become the primary concern, and quality of care will be assigned a secondary position," he contended. In this connection, he pointed out that underestimation on the part of government as to the actual cost of care would result in reduced quality. "Increasing Social Security taxation one-half cent to pay for the care of the medically indigent aged would yield an estimated $1.1 billion," he said. But in financing a program of this magnitude, we are talking about a $4-5 billion bill. Thus, hospitals would be accused of quadrupling hospital care cost when it would be the result of underestimation in the first place."

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Mr. Groner expressed the belief that acceptance of compulsory health insurance by one group would inevitably spread to other groups, "and it *is* compulsory health insurance," he declared. He advised careful, long-range consideration of this problem since acceptance of the social security program could constitute a government commitment having such widespread and complex consequences that it could never be retracted or revoked

State Senator Albert M. Spradling Jr., while ruing the fact that "federal government is pre-empting almost every field of government which states would like to retain," said that nevertheless his own state of Missouri had taxed the people about as much as it could "and we do not have the $60 million required to finance the enabling act of the Kerr-Mills Act to put it into effect at this time."

Senator Spradling, who spoke on the same panel as Mr. Cruikshank, said he estimated it would require $30 million a year for the next two years to implement the Kerr-Mills Act, and a one-half cent sales tax would not cover it. He admonished hospitals that although it was not difficult for them to take money from state and federal governments, they should recognize that this necessarily would involve a certain amount of state and federal government control, and they should consider this consequence carefully. He explained that the greatest help hospitals could give their state general assemblies in arriving at an answer to the problem of care for the medically indigent aged would be to provide the general assemblies with statistics. "We need to know how many will come under the program," said Senator Spradling, "because we have to operate under a budget that has only a certain amount of money in it. State legislatures want to help hospitals but it has to be within the limitation of money available."

George Bugbee, president of Health Information Foundation, New York City, said use of hospital care has increased to one and three-tenths days per person per year as against nine-tenths of a day per person in the general population 30 years ago, due primarily to the movement from home to hospital for medical care. "Oddly enough, and regrettably," Mr. Bugbee said, "medical progress and the fact that infectious diseases have been brought under a large measure of control will not lessen the future need for medical care."

Carlos J. R. Smith, administrator of the Helena (Ark.) Hospital, was installed as president of the Mid-West Hospital Association, and Carl C. Lamley Jr., executive director of Stormont-Vail Hospital, Topeka, Kan., was named president-elect. Registration on the final day of the meeting exceeded 2700.■

SOUTHEASTERN HOSPITAL CONFERENCE OFFICERS (left to right): President-elect, Raymond C. Wilson, administrator, Southern Baptist Hospital, New Orleans; president, E. E. Cavaleri Jr., administrator, "365" Crippled Children's Clinic and Hospital, Birmingham, Ala.

AT SOUTHEASTERN HOSPITAL CONFERENCE—

Hospitals Must Be Willing to Train Personnel To Insure 'High-Level' Service, Director Says

Forward looks to hospital personnel resources during the coming decade, and backward looks at the performance of hospital administrators as managers and at the safety records of hospitals, marked the program of the 24th annual Southeastern Hospital Conference April 19-21 in Memphis, Tenn. More than 1700 registered for the 24th annual assembly of the group.

DR. WILSON

In gearing for the future, hospitals cannot deliver services unless they are willing to train and employ trained personnel, David B. Wilson, M.D., told a general assembly audience. Dr. Wilson, who is director of University Hospital, Jackson, Miss., was a member of a panel on preparing hospital personnel for the future.

"Hospitals cannot continue to operate on the basis of low-skill, low-pay personnel," Dr. Wilson said. "They cannot afford to use untrained personnel and expect to deliver a high level of service."

As medical care becomes more and more complex, Dr. Wilson said, hospitals will be relying more and more on the services of highly skilled technicians. How to train these technicians and how to assure a steady supply of them constitute a problem of major importance, he said. One solution, Dr. Wilson suggested, would be the development of centralized programs—perhaps organized around hospital councils and associations—in which all hospitals could share.

Mrs. Laurene Gilmore, R.N., another panelist, said hospitals don't need more schools of nursing, but need to think of ways to fill the ones they have. Mrs. Gilmore, assistant director of nursing education at Birmingham (Ala.) Baptist Hospitals, said admissions to diploma schools decreased 3.5 per cent in 1960, and that last year diploma schools were the source of 80 per cent of nurses entering the field.

One factor in declining admissions to hospital nursing schools, Mrs. Gilmore said, is the reputation of hospital nursing courses for taking all the strength and stamina the student is able to muster. She urged that hospital nursing courses be set up to be more like schools and less like full-time jobs.

Presenting the viewpoint of a hospital director of nursing, Mrs. Nina Mae Basham said hospitals must redouble their recruitment efforts—starting right now—in order to assure adequate personnel resources for the future. Citing U.S. Bureau of Labor Statistics, Mrs. Basham said in 1965, one million young people will begin work. Hospitals must do their share of recruitment, she said, in order to attract their share of these new workers.

In her discussion of nurse recruitment, Mrs. Basham expressed the belief that nursing education may have become too ideal, that

nursing service personnel are more practical in preparing students for service. "Nurse educators and nursing service people should travel the same orbit in planning educational programs for nurses," she said.

An 11-member panel of educators, administrators and department heads gave frank estimations of current management patterns in hospitals.

There is entirely too much "togetherness" and too much emphasis on "human relations" in present-day management, L. R. Jordan, director of the University of Florida Hospital and Clinics, declared.

"The committee approach is one of the worst things that ever crept into management," Mr. Jordan said. The committee serves a useful role in providing advisory service, he said, but should have no role at all when the time comes to make a decision.

MR. JORDAN

Mr. Jordan, who is also associate professor of management at the University of Florida, said the administrator must be strong enough to say, "This is where we are going."

Clifton Oliver Jr., also on the staff of the University of Florida, said many hospital administrators fail to use the management tools that are available to them. Unfamiliarity with these tools, he said, leads to the attitude that since it is possible to "get by" without them, they must not be very useful anyway.

Another failure that is not entirely their own fault is the failure of many hospital administrators to let employees know that an honest day's work is expected and that nothing less will be satisfactory, Mr. Oliver said. He said personnel shortages or union attitudes are often at the root of this shortcoming.

At a session on hospital safety, Jack Dillman, secretary of the American Hospital Association Committee on Safety, said the odds are six to one that a hospital will have a lost-time accident next year. As a group, he said, hospitals are far behind industry in recognizing the value of an aggressive safety program. Industry knows that these programs pay off, he said, but hospitals seem slow to

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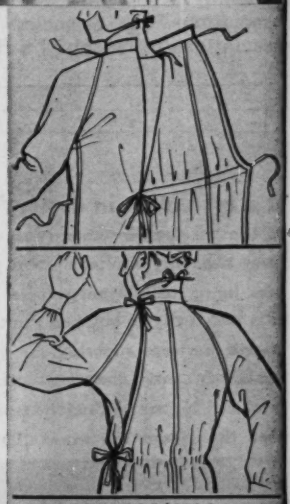

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learn. One bright spot in the hospital safety picture, he said, is the fact that Veterans Administration hospitals last year had the lowest accident rates in 18 states. It is no coincidence, he said, that most VA hospitals have full-time safety officers.

In a business session, the Southeastern Hospital Conference installed E. E. Cavaleri Jr., administrator, "365" Crippled Children's Clinic and Hospital, Birmingham, Ala., as president for the coming year, and named Raymond C. Wilson, administrator, Southern Baptist Hospital, New Orleans, as president-elect. New Orleans was designated as the 1962 convention city. ■

AT QUEBEC HOSPITAL MEETING—

Canada Associations Asked to 'Inspire' Law To Govern Administration of Hospitals

The government of Quebec is prepared to enact legislation governing the administration and operation of hospitals in the province, based on recommendations from hospital and medical associations, the Honorable Jean Lesage, Prime Minister of the Province of Quebec, told delegates attending the opening luncheon at the Quebec Hospital Association's 3rd annual meeting in Montreal, April 19-21.

The prime minister indicated that the government was anxious to assist in every way, but that it did not want to infringe upon the autonomy of hospital and medical associations. He appealed to the associations to "inspire" a Hospital Act in the province by drafting recommendations for the proposed government legislation.

Quebec, the last province to be included under the Hospital Insurance and Diagnostic Service Act, is the only Canadian province which does not have a law controlling all aspects of hospital administration and operation. The sharp rise in hospital operating costs that has become apparent since the province signed the insurance agreement January 1, was pointed out at the meeting.

"It is my profound conviction," said M. Lesage, "that the adoption of a Hospital Act in the Province of Quebec would be a magnificent measure capable of bringing order to a domain which calls for immediate action."

Another plea for unified action on the part of Quebec hospitals came from Jules Gilbert, M.D., director of the Quebec Hospital Insurance Services. Speaking at the hospital insurance session of the three-day meeting, he said, "One of our main problems is the great number of hospital associations, medical associations and unions with whom we must deal. If these groups could get together and agree on their needs it would eliminate needless confusion and our consultations would be more rewarding."

Presenting the hospital's side of the situation, J. Gilbert Turner, M.D., executive director of the Royal Victoria Hospital, Montreal, and president-elect of the Quebec Hospital Association, said that part of the problem is that Quebec's hospitals are confronted with a large accumulated debt which they are unable to pay, and for which the government has made no provisions.

Paul-Emile Cardinal Leger said modern hospitals run the risk of being dehumanized by science and technology. He addressed a banquet at the hospital association convention.

"I know that hospital administration is harassed by things like budgets and the need of coordinating innumerable services," he said. "Still, hospitals must not be organized into rigid and inflexible systems." He viewed the hospital as a laboratory where medical science continues to move ahead with giant steps, but emphasized that "it must also be a place of welcome where modern techniques have not killed hope."

The new officers elected at the convention are: President, J. Gilbert Turner, M.D., executive director, Royal Victoria Hospital, Montreal; vice president, Sister Noemi de Montfort, superintendent, St. Justin's Hospital, Montreal, and treasurer, Jacques Bouchard, president of the Sanatorium St. Jean de Macamic, Amos. ■

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Puerto Ricans May Take ECFMG Exam In Spanish

Foreign medical graduates in Puerto Rico will be permitted to take the American Medical Qualification (A.M.Q.) Examination in Spanish or English up to Jan. 1, 1963, in accordance with action taken at the meeting of the board of trustees of the Educational Council for Foreign Medical Graduates (ECFMG), March 17.

The action came in response to a request made by Enrique Perez-Santiago, M.D., president, Medical Association of Puerto Rico, and Carlos E. Bertran, secretary of the Board of Medical Examiners of Puerto Rico, who appeared before the ECFMG board. Dr. Perez-Santiago pointed out that in view of the fact that Spanish is an official language in the Commonwealth of Puerto Rico, and that a large percentage of interns, residents and medical licentiates of the commonwealth are graduates of foreign medical schools, candidates should be given their choice of taking the examination in English or Spanish.

The action stated that those candidates who obtain 70 per cent or better in the A.M.Q. Examination in Spanish shall receive a provisional certificate in Spanish which will permit them to assume or continue internships or residencies for a period of two years in Puerto Rican hospitals only.

Dean F. Smiley, M.D., executive director of ECFMG, was requested to transmit this recommendation and action to the American Medical Association, the American Hospital Association and the Joint Commission on Accreditation of Hospitals. The means by which the action may be implemented and fitted into current requirements will be taken up by the executive director with the Council on Medical Education and Hospitals of the AMA, with the AHA, with the Joint Commission on Accreditation and with the National Board of Medical Examiners. ■

The law in brief

(Continued from page 94)

As an alternative argument, the plaintiff stressed that when the AMA relinquished the hospital registration program, it requested the Joint Commission on Accreditation to register as well as to accredit institutions. The Joint Commission chose to restrict itself to accreditation, but did make listing by the AHA a prerequisite to accreditation. This indicates, the plaintiff reasoned, that listing is the equivalent of registration because the AMA participates in the Joint Commission. Thus, he proposed, registration is still carried on by the AMA through the JCAH and the AHA. The court would not accept this strained logic.

AN ILL AND A WAY

The plan made payments to some listed nonmember hospitals, and denied payments to listed nonmembers which were not approved by the plan. Hence, the plan had not acknowledged in its practices that listing is the same as registration. In fact, the plaintiff had been a patient in another hospital in the same community—an approved one—and the plan had made payment. This illustrated to the court that impossibility of registration of hospitals did not prevent the patient from enjoying the benefits of his Blue Cross enrollment.

Had the language of the policy been kept up to date, there would have been no reference to registration of hospitals. This would have presented the more simple question as to the right of a Blue Cross plan to deny payments, under contractual terms, where the hospital does not have a contract with the plan and does not enjoy approval by the plan. Previous cases of this type in other states have been resolved in favor of the Blue Cross defendant. (See **HOSPITALS**, J.A.H.A., Feb. 1, 1958, p. 83.)

Service from headquarters

(Continued from page 28)

tween the hospital and the firm. This explanation of service expected can be very involved, but it must be clearly stated. There is no reason why the contract firm could not handle all types of work normally considered within the responsibility of the hospital housekeeping function.

—G. A. WEIDEMIER

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How hospitals and nursing homes can work together

(Continued from page 36)

and rehabilitation care available at homes. As a result, many residents previously referred for hospital care are now adequately served in the home with a combination of improved nursing and medical service.

Physicians in several programs reported that cardiac and serious respiratory cases were once routinely transferred to a hospital but are now adequately treated in the home. The consistency with which local staffs report this development suggests that the upgrading of care in homes can significantly decrease the pressure of hospitals. However, appropriate statistical data have not been maintained for a sufficient length of time to permit testing of these opinions.

Those homes which were studied have been slow to adjust admission policies. Therefore, direct transfers of patients from hospital to home have been limited. Much of this can be attributed to characteristics of this group of nonprofit institutions and may not be found among nursing homes generally, especially not among the proprietary institutions.

LIMITED ADMISSIONS

Several of these homes have limited admissions to persons over 60 years of age; others serve a predominantly Jewish population; while the referring hospital serves a community-wide population. Furthermore, the shortage of nursing facilities has led these nonprofit homes to adopt rather complex devices to control admissions through medical, social and financial study of each applicant. This is a time-consuming process that does not conform to the hospital tempo for discharge. In addition, these homes prefer to diversify their admissions so that they will not become dependent upon one institution for filling their beds. Finally, hospital medical staffs have been slow to learn how to best use these community services.

In only four cases did the rate of direct transfer from hospital to home range as high as 2 to 10 patients per month. Despite this showing, the staffs of the institutions believe this flow will improve in time. Nursing home admission policies are slowly being modified as the effect of integrating physician services begins to be felt. Admitting procedures are being streamlined. The volume of nursing facilities has increased so much that more speed and flexibility become possible. Finally, the hospitals have begun to inform their resident and house staff members more effectively about these nonhospital facilities.

Closely related to the transfer of inpatients between homes and hospitals is the use of outpatient clinics. As medical and nursing services at homes have improved, the use of outpatient clinics at hospitals has declined. All homes in the study reported a limited need except for a few specialized clinics. This is attributed directly to the holding of clinics at the homes. In one case, the number of outpatient clinic visits declined 10 per cent in the first year of the cooperative arrangement, and 20 per cent in the second year.

Maintenance of clinics at the homes may be regarded as a necessary duplication of facilities for a number of reasons. Aged patients are difficult to transport and should not be burdened with long waiting periods at the outpatient clinic. This consideration is seldom controlling because the trend is observed even where institutions adjoin each other. More significant, the holding of clinics at the home has proved advantageous to physicians, home staff and patient. Physicians prefer to treat patients where they are visiting them, and they can readily call in specialists under the cooperative plan. The home staff is relieved of the task of repeatedly moving patients back and forth.

It is impossible now to compare the costs of the home clinic with those of the hospital clinic. Much of the expenditure for physicians and nurses is absorbed in the basic home medical program. Daily moving of patients means extra costs, but the local staffs seem well satisfied with this development and believe it is not costly. Hospital facilities are still used when elaborate equipment is required and the volume is not sufficient for the home to acquire it or when several specialists are involved and collaboration can be best obtained at the hospital.

SUMMARY

The 10 case studies of effective administrative and professional cooperation between hospitals and nursing homes point to three elements that account for their success: respect for institutional autonomy and integrity, executive leadership, and flexibility.

The gulf that bridges nursing homes and other medical care organizations is still great. Although nursing homes and similar institutions are rapidly changing the content of their services, they are still jealous of their independence and integrity. The fears and suspicions they still harbor about powerful hospitals must be recognized and overcome through the development of mutual respect. In all 10 case studies, the cooperation of the homes followed from the careful regard given to their independence and their right to determine the pace at which they would move into the medical and health community.

The hospital administrators proved to be the key and moving figures in achieving progress. They were first committed to a belief in the hospitals' wider community influence and applied this to nursing institutions, as well as to more traditional medical organizations. Each hospital administrator nurtured informal and friendly relationships with nursing home administrators and freely shared his broad knowledge about institutional management and medical care planning. The administrators constantly encouraged their own staffs to act cooperatively in the details of hospital-nursing home relationships.

Finally, these cooperative relationships were permitted to evolve informally and flexibly, and mutual agreements between staffs succeeded in finding common areas for advancement. ■

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ADVERTISER'S INDEX - - - - JUNE 1, 1961

Air-Shields, Inc. 14, 15
American Gas Association 1
American Hospital Association 6, 66, 77, 99, 106
American Sterilizer Company . . . . . 7, 4th Cover
Angelica Uniform Company 101

Bard-Parker Co., Inc.
Div. of the Becton, Dickinson and Company 29
Becton, Dickinson and Company . . . . . 3rd Cover
Brewster, Inc. 27
Burgess-Manning Company 10

Carrier Air Conditioning Company 1
Clad-Rex Corp. 9
Classified Advertising 105
Clements Mfg. Co. 8
Continental Coffee Company 69
Crane Company 90

Davol Rubber Company 30
Diack Controls 103
Diamond Crystal Salt Company 73, 74
Disposable Hospital Products, Inc. 11

Edison Chemical Co., Inc., S. M. 18
Ethicon, Inc. 4, 5

Franklin Products Corp. 72

General Dynamics Corp.,
Liquid Carbonic Division 87
Geneva Hospital Casework
Division of Acme Steel Co. 67

Hard Manufacturing Company 16
Haughton Elevator Company 83
Hollister, Incorporated 21

Jewett Refrigerator Co., Inc., The 24

Kraft Foods Division of
National Dairy Products Corporation 70, 71

Lab-Tek Plastics Company 13
Lilly & Company, Eli 92
Linde Co.,
Div. of Union Carbide Corp. 96
Liquid Carbonic Division
General Dynamics Corporation 87

Massengill Company, The S. E. . . . . 2nd Cover
Minnesota Mining & Mfg. Co. 22, 23
Multitone of Canada, Ltd. 102

National Fund-Raising Services, Inc. 6

Orthopedic Frame Company 28

Parke, Davis & Company 61
Pharmaseal Laboratories 19, 20
Picker X-Ray Corporation 26
Procter and Gamble Company 88

Ross, Inc., Will 65

St. Charles Manufacturing Company 78
Simoniz Industrial Products 9
Smith & Underwood 103
Sunbeam Lighting Company 95

Union Carbide Corp.,
Linde Company Division 96
Upjohn Company, The 25, 54

Vinyl Plastics Inc. 59

West Chemical Products, Inc. 81
Winthrop Laboratories 2, 57
Wyeth Laboratories 62, 63

PICTURE CREDITS

pp. 37, 38, 39 Arthur Leipzig
pp. 47, 48, 49, 51 Photo Lab USIS (India)
p. 53 Fay Foto Service Inc.
p. 55 Arthur Leipzig
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p. 89 Upper: New York Medical College
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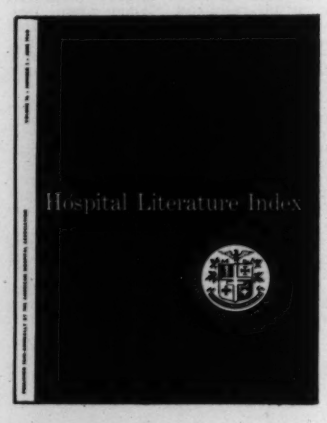

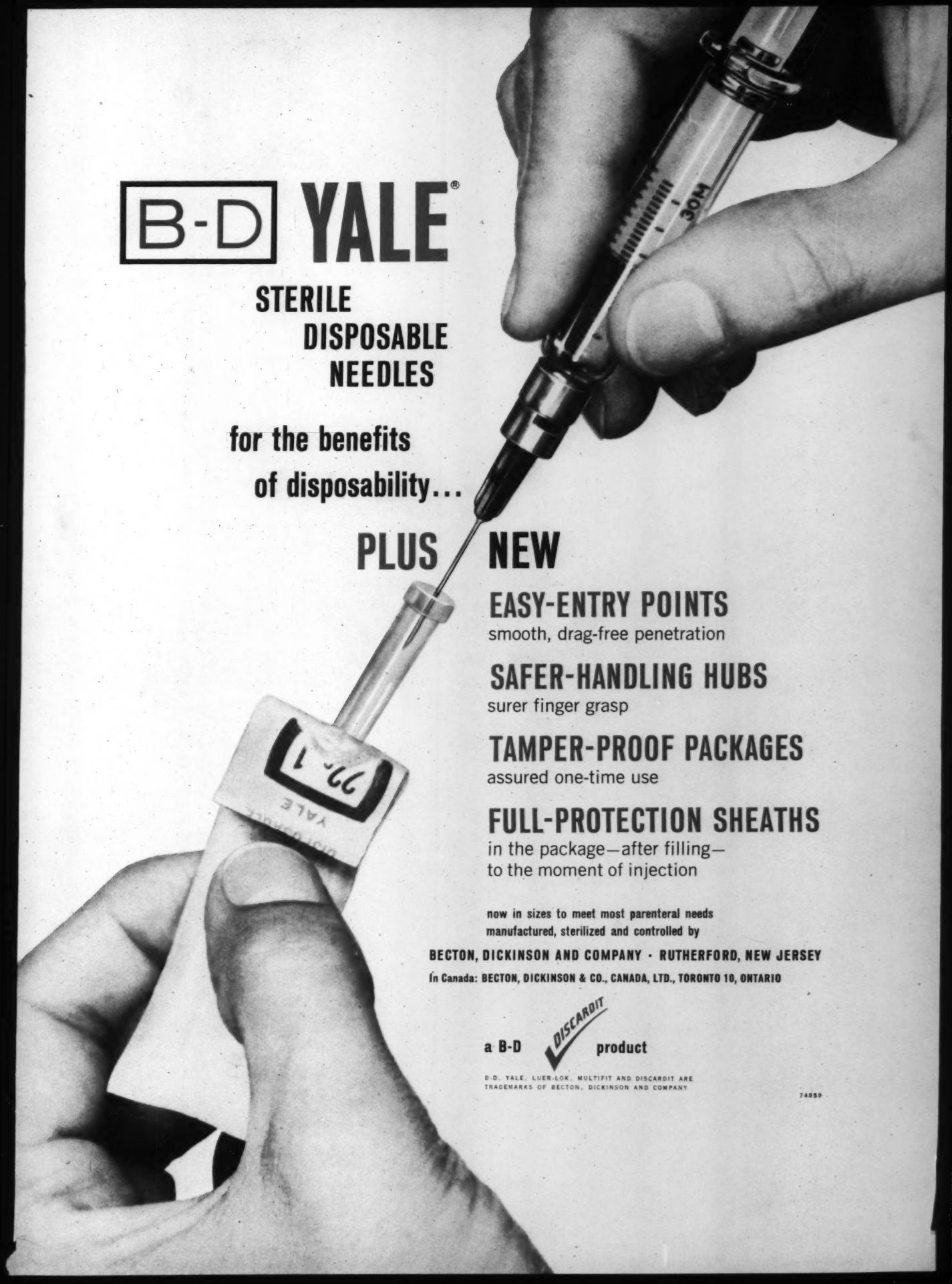

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